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Issue Date: 01 July 2003

CASE NO. 1993-LHC-2205

OWCP NO. 18-35164

In the Matter of:

VERNON LUKE,
Claimant,

vs.

STEVEDORING SERVICES OF AMERICA,
Employer,

and

EAGLE PACIFIC INSURANCE,
Carrier.

Appearances:

William H. Shibley, Esq.
Long Beach, California
For Claimant Vernon Luke

Eugene Chrzanowski, Esq.
Roger Levy, Esq.
San Francisco, California
For Employer/Carrier Stevedoring Services of America and Eagle Pacific Insurance

Before: ANNE BEYTIN TORKINGTON
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

Vernon Luke ("Claimant") brings this claim under the Longshore and Harbor Workers' Compensation Act, as amended (hereinafter "the Act" or "the Longshore Act"), 33 U.S.C. § 901 *et seq.* A formal hearing was held in Long Beach, California on July 15 and 16, 2002, at which all parties were represented by counsel and the following exhibits were admitted into evidence: Administrative Law Judge's Exhibits 1 and 2 ("ALJX-1" and "ALJX-2")[1], Claimant's Exhibits ("CX") 1-8, 12, 13, 15-17, 21, 22, 24-35, 38-46, 48-59, 62-65, 70, 74, 76, 77, 80-90, 92-94,[2] 96-105;[3] and Employer/Carrier's Exhibits ("RX") 1 through 79. See Transcript, ("Tr.") at 10-11, 20-21, 27.[4]

The parties agreed that the deposition of Claimant's expert witness, Dr. John Larsen, which began on July 11, 2002, would be concluded Post-Trial. This Court received the Post-Trial deposition of Dr. Larsen on January 29, 2003. This exhibit is hereby admitted into evidence as CX-106.[5] The deposition of Claimant's expert, David Eckhous was taken on July 10, 2002. At the time of trial, the transcript was not yet available. This Court received the deposition transcript of Mr. Eckhous on January 29, 2003. This exhibit is hereby admitted into evidence as CX-107.

On January 30, 2003, Claimant submitted his Post-Trial Brief. On January 22, 2003, Employer submitted its Post-trial Brief. These are hereby admitted as Administrative Law Judge's Exhibits 3 and 4.[6]

On April 28, 2003, the Director, OWCP filed a Response to this court's Order to Show Cause issued April 25, 2003, why the court should not grant Employer's Application for Section 8(f) relief. The Director's Response is marked and admitted as ALJX-5.

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[1]Administrative Law Judge's Exhibits are Claimant's Pre-Trial Statement ("ALJX-1"), and Employer/Carrier's Pre-Trial Statement ("ALJX-2"). These were inadvertently left out at trial, but are hereby admitted into evidence.

[2]CX-93 is blank.

[3]CX-96 is blank; Claimant's Exhibit 105 was offered and admitted Post-Trial, on February 10, 2003.

[4]Hereinafter Employer/Carrier will be referred to simply as Employer. Employer's Exhibit 79 was offered Post-Trial on December 9, 2002, and is hereby admitted into evidence.

[5]CX-106 consists of two volumes: pages 1-44 (deposition taken on July 11, 2002) and pages 45-115, deposition concluded on November 1, 2002.

[6]ALJX-3 is Claimant's Post-Hearing Argument, ALJX-4 is Employer's Post-Hearing Argument.

Stipulations: The parties agreed to the following stipulations:

1. The parties are subject to the Act;

2. Claimant and Employer were in an employer-employee relationship at the time the injury occurred;

3. The alleged injury sustained on June 24, 1987, in Long Beach, California, arose out of and in the course of employment;

4. Claimant filed a timely claim for compensation;

5. Employer had timely notice of the injury;

6. Claimant's average weekly wage at the time of injury was $1,681.37;[7]

7. Claimant has not returned to his former job and is not now working;

8. Employer voluntarily paid compensation for temporary total disability from June 25, 1987, through May 31, 1990, and commenced payment of permanent partial disability on June 1, 1990.

9. There was a period of non-payment from June 21, 1993 through April 11, 1994.[8]

10. Claimant was advanced $8,000 by Employer on December 10, 1988, and $1,500 on June 20, 1991. Employer has paid a total of $460,167.51, including advances, through July 12, 2002.[9]

The Court accepts all of the foregoing stipulations as they are supported by substantial evidence of record. See *Phelps v. Newport News Shipbuilding & Dry Dock Co.*, 16 BRBS 325, 327 (1984); *Huneycutt v. Newport News Shipbuilding & Dry Dock Co.*, 17 BRBS 142, 144 fn. 2 (1985).

[7]Clamant has stipulated to the amount alleged by Employer in its Post-Trial Brief. See ALJX-3, p.2, ALJX-4, p.4.

[8]See Tr.399-400, 432.

[9]See Tr.399-400, 432.

Issues in Dispute:

1. What is the date of maximum medical improvement?

2. What is the nature and extent of Claimant's disability?

3. Is Claimant entitled to payment for the period of June 21, 1993 through April 11, 1994?

4. Is Claimant entitled to Section 14(e) penalties for this same period?

5. Is Employer entitled to Section 8(f) relief?

6. Is Claimant entitled to attorney's fees and costs?

SUMMARY OF DECISION

Claimant reached maximum medical improvement on June 1, 1990. He was permanently totally disabled from June 1, 1990 through February 8, 1993. Claimant became permanently partially disabled on February 9, 1993, and is capable of sedentary work. He has a residual wage earning capacity of $264.00 per week, giving him a disability rate payable at the maximum amount. Claimant is also entitled to payment for a twenty percent loss to his right knee at the scheduled rate, which is subsumed in his payments for permanent total disability and for permanent partial disability under Section 8(c)(21). Claimant is entitled to payment for the period of June 21, 1993 through April 11, 1994, with interest thereon, but is not entitled to penalties for the same period. Employer is entitled to Section 8(f) relief. Claimant is entitled to attorney's fees and costs for the issues he has prevailed on.

SUMMARY OF EVIDENCE

Claimant's Testimony:

Claimant Vernon Luke testified on his own behalf. Claimant was born in 1943. Tr.72. He had worked as a marine clerk since 1979, and was classified as a class A longshoreman.[10]

[10]Claimant testified that he transferred to the marine clerk union at that time, partially due to a right knee injury he suffered in 1967, playing football in the armed services. Tr.46-48, 281. On cross-examination, Claimant stated that he has had two surgeries to his right knee stemming from this football injury, prior to the subject accident, and he has been receiving a service-related disability of $200 per week since the 1970's. Claimant further stated that in 1975, he fell through a hatch, injuring his right knee again. Claimant then denied having trouble with his right knee as far back as his original knee injury in 1967. Tr.282-285. Claimant agreed on cross-examination that the switch to the clerk's union was because he was suffering from swelling and stiffness in his knee. He stated that this was due to an injury in 1977, and that he had ongoing problems between 1977 and 1980.

Tr.46-48. Claimant was working as a "floor runner"[11] on June 24, 1987, the date of the accident. Claimant's job was to drive a jeep and keep up with the top handlers.[12] On the evening of June 24, 1987, Claimant was getting back into his jeep when he was run over twice by a top handler. Claimant was trapped inside the jeep for about 40-45 minutes. The firemen cut him out of the jeep and he was taken to St. Mary's Hospital. Tr.53-56. Claimant suffered a broken pelvis and was operated on a few days following the accident. He was in traction for four months following the surgery. Claimant testified that his right knee was put into traction because he "had so many fractures." He suffered injuries to his arm, hip, shoulder, neck and both legs as well. Tr.61-62.

When Claimant was released from St. Mary's Hospital, he went to Casa Colina for rehabilitation. Tr.62-63. Claimant testified that while at Casa Colina, he was taken back to the hospital four or five times because he would stop breathing while he slept. Claimant testified that he had never had any problems with sleep before the accident. Tr.63-64. On cross-examination, Claimant did not remember, prior to the accident, occasionally falling asleep at work and needing someone to wake him up. Nor did he recall telling the doctor at Casa Colina that he had a history of falling asleep fairly easily at any time of day or night, voluntarily or involuntarily, prior to the accident. See CX-34, p.45. He did not recall telling Dr. Eric Feldman in 1988 that he had a history of sleep apnea syndrome. See, CX-65, p.144. Nor did he recall telling Dr. Peter Fotinakes at St. Mary's Hospital in 1987 that he had a similar history of sleep apnea. See, CX-35, p.46.[13] Tr.287-292.

On re-direct, Claimant recalled his consultation with Dr. Fotinakes in great detail. He recalled that he was on six different medications at the time – Demerol,[14] Prozac,[15] Morphine,[16]

He did not know when these problems stopped, but he could not recall having any problems with his right knee just before the injury on June 24, 1987. Tr.285-286.

[11]A floor runner "record[s] storage and discharge from the ship and from the yard of all containers either going aboard or being discharged and the placement of where it is placed at – in the yard." Tr.50.

[12]A top handler is a massive mobile crane that picks up and moves the containers on and off the trailers and either stores them or sends them to be loaded on the ships. It measures approximately three or four stories high, and fifteen feet wide. The wheels, depending on the machine, can be about two stories high. It weighs approximately 100,000 pounds. Tr.51-53.

[13]Dr. Fotinakes' report includes statements he attributes to both Claimant and his wife regarding Claimant's sleep patterns. See, CX-35, p.46.

[14]A narcotic analgesic prescribed for relief of moderate to severe pain. *The Pill Book*, 7th ed., 1996, p.675.

[15]A selective serotonin reuptake inhibitor-type antidepressant, prescribed for depression, as well as the treatment of bulimia, obesity and obsessive-compulsive disorder. *The Pill Book*, 7th ed., 1996, p.465.

[16]A narcotic analgesic, prescribed for the relief of moderate to severe pain. *www.rxlist.com/cgi/generic.*

Valium,[17] Ativan,[18] and Percocet.[19] He recalled that he had been given his last dose[20] two or three minutes prior to his consultation with Dr. Fotinakes. He recalled telling Dr. Fotinakes about his work schedule at the time, which was working "from 6 p.m. to 8 a.m, depending." Claimant recalled telling Dr. Fotinakes that he sometimes napped in his car during his shift, and that he sometimes fell asleep in front of the television at home. Claimant recalled that he was not present when Dr. Fotinakes spoke with his wife regarding his sleep patterns. Tr.371-374.

After being released from Casa Colina, Claimant returned home. He testified that his doctors wanted him to use a wheelchair to get around, but he had "made [him]self a promise" that he "would never be confined to a wheelchair."[21] He was able to get up and walk once released from Casa Colina. Tr.65. Claimant was then sent to see Dr. Douglas Jackson who enrolled him in a pain program at Long Beach Memorial hospital. The program lasted one or two months. During this time, Claimant was using a "cane" to get around, similar to the ones he used at trial. He was given these canes (or hand crutches) at Casa Colina.[22] Tr.66-67. Claimant testified that Dr. Jackson told him he needed a knee replacement, but recommended against it because of Claimant's age and his weight. It would be beneficial for Claimant to wait until the technology advanced, because he'd "wear it out in no time." Tr.72.

When he completed the pain program, Claimant attempted to go back to work. He lasted about 40 minutes before he began experiencing excruciating pain, and began sweating profusely.

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[17]A benzodiazepene tranquilizer, prescribed for the relief of anxiety, tension, fatigue, agitation, muscle spazm, seizures, irritable bowel syndrome and panic attacks. This drug should be avoided by sufferers of severe depression, sleep apnea, and kidney disease. It should not be taken in conjunction with tranquilizers, narcotics, barbituates, or antidepressants. *The Pill Book*, 7th ed., 1996, p.317-319.

[18] A benzodiazepene tranquilizer, prescribed for the relief of anxiety, tension, fatigue, agitation, irritable bowel syndrome, panic attacks and chronic sleeplessness. This drug should be avoided by sufferers of severe depression, sleep apnea, and kidney disease. It should not be taken in conjunction with tranquilizers, narcotics, barbituates, or antidepressants. *The Pill Book*, 7th ed., 1996, p.628-631.

[19]A narcotic-analgesic combination, prescribed for relief of mild to moderate pain. *The Pill Book*, 7th ed., 1996, p.877-878.

[20]Claimant did not specify whether "his last dose" included all, some or one of these medications.

[21]Claimant testified that he only uses a wheelchair when he visits the VA hospital, and only because he has such a long distance to travel there. Tr.66. When he arrives, he is asked if he would like a wheelchair because of the distance, and he accepts. He asserted that he was given a prescription for one from the VA, but he does not have it. They never provided him with his own wheelchair, and he never asked for one. Tr.360-361.

[22]Per Claimant's treating physician Dr. Larsen, Tr.36, these hand crutches are grasped with your hands and a band goes around your wrist. Claimant later testified that at some point, he felt he would benefit from having some sort of scooter. He stated that he did not know if he could get one from the Department of Labor, but that he had asked Dr. Stanford Noel, who was treating him at the time, if he would help him get one. Dr. Noel refused. Tr.70-71. Claimant testified that he got along well with Dr. Noel. Tr.73. As far as he knows, Dr. Noel is a pretty good guy. Tr.334.

He was told, "I'm sorry. You can't stay here. You've got to go." Tr.67-68. On cross-examination, Claimant stated that he did not go to the hospital after leaving work in so much pain. He just went home. Tr.312.

Claimant testified that he was then ordered to see Dr. James London. During one visit, Dr. London made Claimant wait for approximately one hour in the examining room. When he finally examined him, Dr. London had Claimant stand and attempt to bend in various directions without the help of his crutches. When Claimant was trying to bend forward, Dr. London told him he could bend further and pushed him down. Claimant "yelled from the pain and hit the floor." Dr. London then refused to help Claimant up, saying, "get up the best way you can." Dr. London then turned and walked out of the room. Claimant testified that he tried to get up for about ten minutes, and then began hollering for help. The person working the front desk came in and informed Claimant that she was ordered by Dr. London not to help him. Claimant asked her to get the person who drove him to the office, which she did. Claimant then dressed and left. He refused to return unless he could bring someone with him. Dr. London would not allow this, so he stopped going to see him. His benefits were then cut off for a year. Tr.74-76.

On cross-examination, Claimant admitted that he did go back to see Dr. London after the pushing incident, but he took someone with him that time. It was because Dr. London would not let the person stay during the examination that Claimant refused to return. Claimant denied that during this visit, Dr. London was trying to ask him questions that he refused to answer. He stated that "Dr. London told me I could have nobody in the room with me." His refusal to submit to an examination "had nothing to do with him asking me questions." Claimant recalled saying in his deposition on February 10, 1994, that Dr. London had threatened to put him in the hospital and give him medication to make him answer the questions. Claimant asserted that this comment on Dr. London's part came out of the blue, and not because Claimant refused to answer his questions. Tr.313-317. When asked if he filed any complaint against Dr. London for pushing him down, Claimant responded that he "thought it had occurred." However, he did not have any proof that he had filed a complaint. Tr.317-318.

On cross-examination, Claimant denied having difficulties getting along with any of his other physicians. He then remembered a problem with Dr. Fotinakes. Claimant felt that Dr. Fotinakes "abused" him. Dr. Fotinakes performed a procedure without administering medication. Claimant remembered having a problem with Dr. H.M. Gulack. He liked him, but did not appreciate his racist jokes. Claimant asserted that he had resolved that problem. However during his deposition on September 5, 1990, Claimant asserted that he did not like Dr. Gulack's bedside manner, and he disliked the doctor "immensely." Tr.327-329. On re-direct, Claimant stated that he saw Dr. Gulack recently for "therapy." Tr.378. Claimant did not recall having problems with Dr. Kim, however during the same deposition in 1990, Claimant testified that Dr. Kim had refused to see him on one occasion, sending him to the emergency room instead, so Claimant "told him he

was fired." Tr.327-329.[23] Regarding Dr. Geoffrey Miller, Claimant testified that he has seen him about ten times. Dr. Miller usually spent about ten minutes with him at a typical visit, and had never given Claimant an hour and a half exam. Nor has he ever conducted any physical tests on Claimant. Tr.89-90.

Claimant then went to see Dr. Joseph and Dr. Isaacson at the Kerlan/Jobe clinic for his back, knees and hip.[24] He could not recall who referred him there. Dr. Isaacson diagnosed his hip pain as a cyst. Claimant testified that his hip pain had been present since the time of the accident and at the time of Dr. Isaacson's diagnosis, the pain was continual, with a rating of eight or nine, on a scale of one to ten, ten being the most excruciating pain.[25] Tr.78-79.

Claimant stated that he was told by the doctors at Kerlan/Jobe that the screws in his pelvis had come out of his plate. They told him that the screws needed to be taken out or replaced because they were "floating around." Tr.80. However, Claimant testified that his pelvis does not bother him like it did before. He has "pain so infrequently now that it is a great relief." Tr.83. Claimant then testified a few moments later that he gets stabbing pains in his pelvic region, in the front, inner-thigh area. He is not being treated for his pelvic pain at the present time. Tr.98-99.

Claimant stated that Dr. Jackson, Dr. Feldman, Dr. Fonseca, as well as Dr. Isaacson and Dr. Joseph [sic] at Kerlan/Jobe, all told him that they recommended he undergo low back surgery. Claimant did not have surgery because none of them could get approval from the insurance company. He was never given an explanation as to why. Tr.83-85. On cross-examination, Claimant re-affirmed his belief that Dr. Fonseca recommended back surgery. When told that Dr. Fonseca denied such a recommendation during his deposition, Claimant still stood by his assertion that Dr. Fonseca had told him he was requesting approval to perform surgery. Tr.337-340.

Claimant has been seeing Dr. Larsen most recently. Dr. Larsen also suggests low back surgery. Tr.85. Claimant has recently had four or five epidural injections in his back, which have helped. Tr.92. Dr. Larsen is intending to conduct back surgery in the near future, and Claimant is scheduled for an MRI of his low back. Tr.99. On re-cross, Claimant did not recall telling Dr. Larsen that he did not want to have back surgery when it was recommended to him in 2000. Tr.444.

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[23]The undersigned cannot find any records of Dr. Kim's in the exhibits. Thus, Dr. Kim's first name is unknown.

[24]There is some confusion in the record regarding who Claimant was treated by at Kerlan/Jobe. Claimant refers to them as Dr. Joseph and Dr. Isaacson. However, according to the records, it was Dr. Andrew Spitzer, and Dr. Joseph Isaacson. See, CX-94, 95.

[25]Claimant has had surgery to remove the cyst and is "doing a hundred times better," according to his deposition testimony of Friday, March 3, 2000. See, RX-69, p.424.

Regarding his current back pain, Claimant indicated that he has constant pain in his low back near the tailbone, in the middle. Tr.83. He suffers from pain shooting into both legs, down to his toes, accompanied by numbness. All of the toes on his right foot are numb. He gets stabbing pains in the bottom of his feet, as well as in the pelvic region and along the back of his legs.[26] Tr.85. Claimant also stated that his pain varies. If he walks without his canes for too long or too far, his back gives out on him, and he "can't even stand up straight." He needs his canes when walking on anything not level. Tr.99-100.

Claimant had knee surgery in the mid-nineties, at the recommendation of Dr. Gil Tepper, to whom he was referred by Dr. Alan Fonseca.[27] Dr. Tepper operated on Claimant's right knee about three or four times, and his knee did improve. Claimant stated that prior to the accident, he could flex his knee to 110 degrees, after the accident he only had about fifty or sixty degrees of flexion, and after the surgery, he had full flexion. This has since changed though, because "the machine that I had that they gave me broke, and before we got a replacement, the knee stiffened up again." Tr.80-82. Dr. Tepper released Claimant because he could do no more for him. "[H]e said there wasn't much left to the knee." Tr.83. Regarding his current knee pain, Claimant stated that his right knee "is so stiff and so sore, that's basically the problem. I don't have the range of motion that I had." Tr.100.

Claimant attended vocational rehabilitation training at the Department of Labor. They "gave him a bunch of tests" to see if he "could return back to the job place." Claimant stated that he remembered falling asleep "most of the time" that he was at his training. Claimant stated that he did so because he "was in pain." Tr.369-370. He did not remember what year this was, but after seeing a report, he recalled that this training ended in February 1993. He has not received any more rehabilitation training since this time, but would go to a work hardening program to get back into the work force if it were available to him. Tr.86-89. Claimant stated that no one else has offered to help him find work. No one has told him they could re-train him for some other type of work. Claimant stated he loved his job, and wishes to return to work. Tr.101. On re-direct, Claimant stated that he had requested retraining, but none was ever offered to him. Tr.377.

Claimant was asked if he thought that there was some type of marine clerk work he could perform in his condition. Claimant asserted that it was his dream to go back to clerking, but he could not perform the work in his present condition. Claimant was referred to his deposition of February 10, 1994, in which he stated that he could work as "super cargo" clerk,[28] but that he had

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[26]However, at his March 3, 2000, deposition, when asked "did he ever get shooting pains down into [his] hips and legs anymore," Claimant responded "No." See, RX-69, p.425.

[27]Dr. Fonseca is a board certified orthopedist who treated Claimant between 1993 and 1995. Claimant was referred to Dr. Fonseca by his family physician. See, RX-68.

[28]"Super cargo" entails directing the loading and unloading of the ship, directing the workers, the storage of cargo, and keeping a ledger of all the activities performed. Claimant testified that it requires boarding the ship,

not tried to go down to the hall and get the job because "[i]t doesn't work that way." Tr.351-352. Claimant did recall telling Judy Jones, at Memorial Rehabilitation Hospital, as far back as 1991, that he was capable of working as a clerk checking containers, as a yard dispatcher, computer operator, super cargo, coke-dock super cargo, out gate, chief truck delivery, trade pack tower, doc 247, as well as talking on the microphones. See, RX-75, p.502. However, Claimant recalled giving this as a wish list, and not jobs he thought he could actually perform. Tr.353-354.

On cross-examination, Claimant stated that he has been offered jobs off the waterfront, as a basketball coach and football coach at Mount San Antonio College. Claimant stated that he could not perform these jobs, as he would have to show the players what to do, and he'd have to work out with them for at least three to five hours. Claimant then admitted that the people who offered him the jobs knew about his condition, yet offered him the job, regardless. Tr.355-356. On re-direct, Claimant stated that the job as football coach required him to walk on uneven terrain. Tr.366. On cross-examination, Claimant testified that he had worked as a security consultant for an auction at one time making about $150 a week, and around 1990, they asked him to come back to work. Claimant asserted that at the time, he had to go to therapy and was unable to accept their offer. He has not gone back recently to inquire about work because the man running the outfit then retired. The people running it now do not know him. Tr.356-358.

Claimant was then asked about the physical requirements for the auction security consultant job. He stated that it entailed maintaining the auction yard, watching the cars to make sure none were stolen, and running errands in his car, including going to the bank, which he is able to do. Tr.358. When asked about the physical qualifications of this job on re-direct, Claimant stated that it required walking a mile per day. It also required getting in and out of a car, as well as sitting and standing. He did not think he was physically capable of performing the job. Tr.377-378. On re-cross, Claimant could not recall testifying at his 1990 deposition that his duties at the auction were watching the auction, getting the security for the auction "or recommend, do research, find out what would be the best security for the place." Tr.389. It was general consulting that did not require manual labor. Claimant admitted that these were the requirements of the job, that it did not require walking a mile, driving to the bank, or doing security. Claimant admitted that "basically what [he] did" was find people to do those types of jobs. Tr.388-391. On re-direct, Claimant testified that he also had to walk as well as go to the bank from time to time, but he did not recall counsel ever asking him such questions at his deposition in 1990. At the time of the deposition, Claimant had recently undergone penile repair surgery, which required a two to three month recovery, thus he could not perform the job. Tr.394-395.

Claimant testified that he is six feet six inches tall, and at the time of the accident, weighed 295 pounds. He stated that his weight has not always been high. Tr.57. When asked on cross-examination if he remembered telling the doctors at the hospital that he weighed 350 pounds, Claimant stated that he did not, and that the doctor must have asked someone else. Claimant denied that his weight has been consistently around 335 to 355 since the accident. At the time of

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moving around the yard, climbing stairs, bending, and stooping. Tr.364.

trial Claimant stated he weighed 340 pounds. He stated that the most he has ever weighed was 390 while he was laid up in the hospital after the accident. This was his weight when he left Casa Colina. He then testified that he weighed 320 pounds when he saw Dr. Jackson in January 1988, about a month after his release from Casa Colina.[29] Tr.276-278. Claimant could not recall telling any doctor that he weighed 390 pounds. Tr.347. Claimant was reminded of his deposition testimony when he stated that he used to weigh 245-250 when he was a longshoreman. When asked what caused him to gain 50 pounds to put him at 295 at the time of the accident, Claimant stated "I guess working as a clerk. I don't know." When asked if he was having a problem putting on weight even before the accident, Claimant responded "It depends on how you look at it. I don't know how long I had been at 295. It had been within a year, so the answer would be yes." Tr.345-347.

Claimant testified that prior to the accident, he was able to walk great distances, and able to run, even with his knee problems. Tr.61. Claimant was using crutches (or canes) at the time of trial. He testified that he does not always need them. He tries to walk without them on a daily basis. He does not need them around the house because he has things to hold onto. He continued that he has a pair that he keeps in the car and one pair in the house. He usually doesn't need any to get from the house to the car "because it's not that great a distance." Tr.92-93.

Claimant was advised by some of his doctors to get a specially constructed car, which he did.[30] He was not sure whether the employer had paid for that or not. Claimant does not use the car, however. It needs repairs so it sits in his driveway. Tr.102. Claimant testified on cross-examination that he has removed the hand controls from the car, and is now driving a different car without any controls. He testified that he does not always need the controls to drive. Tr.266-267. On re-direct, Claimant explained that he has some difficulty getting in and out of a car because his knee "doesn't have that much motion in it." He stated that it takes him some time to manage "because of the back situation along with the knee." He continued: "I have to get one leg in first, and then I sit down on the top of the seat and slide down into the seat. And then I can put my other leg in, turn to the side and bring my other leg in and grab the door." Tr.374.

Claimant testified that it was also recommended, starting from his time at Casa Colina, and up to the present, that he get a special sports wheelchair, but that has never been approved. He has "had prescription after prescription written for it." Tr.93-94. On cross-examination, Claimant had no explanation for why there is no prescription for such a chair in any of his

[29]Dr. Jackson's report states Claimant weighed 335 pounds, but Claimant stated that it was more like 320. Tr.279.

[30]The car has hand controls. Tr.93.

medical records. He gave it to his attorney at the time.[31] Tr.335-336. Claimant was provided with a specially equipped bed, but it is in storage and has never been moved to his current residence. Tr.103. On re-direct, Claimant testified that it was put in storage when Claimant lost his house for failure to make the payments. He could not move the bed out of storage because it was too heavy and he did not have the money to pay someone to move it for him. Tr.380. On re-cross, Claimant was asked if he had made any inquiries into finding help to move the bed. He stated that he had asked his friends and family who said they would help him, but he has not had the opportunity to get a vehicle to move it. The bed has been in storage since June 24, 1997. Tr.393-394.

Claimant testified that he is currently taking 500 or 750 milligrams of Vicodin[32] per day. Tr.102. He stated that he was given a prescription by Dr. Rabin, as well as by the Veterans Administration ("V.A.") Hospital. He does not have a prescription from Dr. Larsen, but Dr. Larsen is aware that Claimant is taking the drug. Claimant testified that he had taken two Vicodin that day, one in the morning before the proceedings began, and one at approximately 2:30 p.m. Tr.258-259. On cross-examination, Claimant testified that his prescription was last renewed in February. He offered to bring it in to show the court. Claimant then brought a bottle to court on the second day of testimony. The prescription was dated April 9, 2001, and stated "No refills." Tr.318. When asked about the prescription he had from February 2002, Claimant stated that it was at home. He did not know why he had failed to bring in the correct bottle. Claimant was instructed to return home and bring back his current prescription bottle. Tr.319.

Upon returning after the lunch break, Claimant testified that he had gone home to look for the current bottle, which he kept in a box where he keeps all of his empty medicine bottles. He cold not find it, however, because his brother threw the box out. He looked, but was unable to find any other records of his prescription. Claimant testified that the prescription was given to him by Dr. Marinow or Dr. Bernadette at St. Mary's Hospital. He did not recall the last time he had seen these doctors. Claimant testified that the pills he had brought in the day prior had been transferred to that bottle because that bottle is smaller and easier to carry in his pocket. Claimant stated that he could try to get the prescription from some other source. Tr.440-442. On re-cross, when asked why he had not asked his brother the night before, where the "February" bottle of Vicodin was, Claimant stated that he "thought [he] had everything in that was from February." He did not notice that the bottle he brought in that morning was from April 2001. Tr.443-444.

Claimant asserted that he has been taking approximately one Vicodin per day, but in the last five months, he had taken two per day about two or three times a week. Claimant then added that he sometimes takes aspirin instead. He takes "a pill every day. It's not necessarily Vicodin

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[31]On re-direct, Claimant testified that he gave the prescriptions to his sister, Naomi Tall, who was acting as his attorney at the time. They have since had a falling out and Ms. Tall refused to return all of his records. Tr.365.

[32]A narcotic-analgesic combination, prescribed for mild to moderate pain relief. *The Pill Book*, 7th ed., 1996, p.877-878.

that I take every day." Claimant explained that he takes Vicodin "when I get to the point to where I can't stand the pain." Recently, he has needed to take it about 20 to 25 days out of the month. It depends on his activities. When asked what sort of activities he is able to participate in when he is so disabled, Claimant replied that he tries to keep himself as active as possible. "I am not a person to lay down and die." These activities involve "getting up and trying to keep [himself] mobile." Tr.260.-262. When asked which sort of activities cause him to take Vicodin, Claimant stated any activity involving constant moving, or "anything where I have to do any type of long walking," which he does not do very often, only "about five times a week." Tr.263.

Claimant was asked to elaborate on this activity. Claimant testified that he tries to get out with the kids, referring to "the kids over at Poly." He goes to their high school basketball and football games and sits in the stands. He is capable of sitting in the stands for a two hour game. Claimant agreed that he had been able to sit in the courtroom all day as well. When asked if Mr. Eckhous's report stating that Claimant can only sit for 20 minutes at a time was incorrect, based upon his previous testimony, Claimant responded that it depends on how much pain he is in. He stated that there have been times when he could sit for a couple of hours. He admitted that he had sat in his car for five hours the day he was observed by the investigator. Tr.263-265.

Claimant was asked about the investigator's report stating that he was observed sitting in his car for five hours one day in December of 2001. Claimant asserted that he frequently does that because he is in so much pain he doesn't want to move to get out. Tr.101. Claimant explained on cross-examination: "I be [sic] in a lot of pain, and I wait until the pain is subsided enough to where I can make it into the house in fairly good comfort." Sitting in the car is less painful than trying to get up and move into the house. Tr.267. Claimant was asked about long trips in his car he has made. He testified that he has not personally driven further than Riverside since the accident. As a passenger, he has been driven to Sacramento and Oakland. Claimant then corrected his testimony when referred to his deposition of March 5, 2000, and stated that he shared the driving to Sacramento to see his son once. This trip was made in a "little T-bird." Tr.273-274. Claimant also drove with his brother to Bullhead City, Nevada once. This drive is the same as the distance to Sacramento, seven or eight hours. Claimant was in the car the entire trip. Tr.275-276.

Claimant was asked about his income. He collects a little over $2,400 a month from workers' compensation, $500 a month from Social Security, $200 a month from the VA, for a total of $3,200 per month. Claimant stated that this has no influence on the fact that he has not attempted to return to work. Tr.359.

Testimony of Brian Keith Deline:

Mr. Deline is an investigator for Pianavilla Agency.[33] He was examined by Claimant's attorney, Mr. Shibley.

Mr. Deline followed Claimant on two occasions. On the first, December 6, 2001, RX-77, he testified that he observed Claimant sitting in his vehicle at 6:30 a.m. when he (Mr. Deline) arrived; he observed that Claimant was not asleep. Tr.251-252. Claimant drove around the neighborhood at 9:45 a.m. and returned to his residence. Claimant exited the car at 11:50 a.m. and went into his residence. Tr.252. According to the witness, Claimant did not limp nor did he use crutches. Mr. Deline left at 1:00 p.m. Tr.253.

On the second day, December 11, 2001, RX-77, Mr. Deline arrived at Claimant's residence at 7:00 a.m. and found Claimant in his car. Claimant drove the car with a older male passenger at 10:50 a.m. Tr.253-254. They drove to a strip mall where Claimant remained in the car while the passenger went into the mall. They drove off at 11:30 a.m. and went to a shopping plaza. Again, Claimant stayed in the car and the passenger went into the shopping plaza. They returned to the residence[34] and Claimant walked into it; he did not limp or use crutches, nor did he carry anything. Tr.255.

Medical Testimony:

Dr. John M. Larsen:

Dr. Larsen was called by Claimant and testified in a perpetuation deposition in lieu of trial testimony. The first portion of the deposition was taken on July 11, 2002,[35] a few days prior to the hearing. The deposition was concluded on November 1, 2002.[36]

Dr. Larsen has been a member of the American Board of Orthopedic Surgery since July 1994 and is licensed in California and Nevada. CX-106A.[37] He graduated from the University of

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[33]Mr. Shibley, who called Mr. Deline as a hostile witness, did not ascertain for whom he worked. I deduce that this witness was employed by the Pianavilla Agency based on RX-77 and ALJX-2, p.2.

[34]Per RX-77, p.511, the surveillance log, Claimant and the passenger returned to the residence at 12:15 p.m.

[35]At that time, Eugene Chrzanowski represented Employer and Mr. Shibley represented Claimant. That portion of the deposition is covered by pages 1-44 of CX-106.

[36]Roger Levy represented Employer (by telephone) and Mr. Shibley represented Claimant at the second portion of the deposition, covered by pages 45-115 of CX-106.

[37]CX-106A is Dr. Larsen's curriculum vitae, and is attached to the first volume of his deposition.

Washington Medical School in 1986, did a surgical internship at Los Angeles County/University of Southern California Medical Center in 1986-1987, an orthopedic surgical residency at the same institution in 1987-1991, and a fellowship in reconstructive spinal surgery at Rancho Los Amigos Medical Center in Downey, California in 1991-1992. He is in private practice.

Dr. Larsen testified on direct that he first saw Claimant on August 24, 1999 and is Claimant's current treating physician. The witness stated that he had seen Claimant eight times by the time of his testimony on July 11, 2002. He did not believe Claimant was manipulative. CX-106, p.37. He opined that as of July 10, 2002, Claimant is in need of surgery to decompress his back, but was unsure at what levels. CX-106, p..8. Later, Dr. Larsen testified that he had recommended back surgery in the past but Claimant did not want it, although now he does want it because of an increase in his symptoms. CX-106, p.59. Dr. Larsen has ordered epidural injections, but they did not work. CX-106, p.61. Dr. Larsen recommends back surgery in spite of the fact that Claimant's diabetes would put him at higher risk for the surgery itself, and for complications following it. CX-106, p.62. Dr. Larsen stated that Claimant is temporarily totally disabled because of his need for back surgery. CX-106, p.67. He also testified that Claimant's diabetes is related to the industrial injury because Claimant gained weight after the injury because he became inactive. CX-106, p.76. On cross-examination Dr. Larsen testified that he would probably change his opinion that the diabetes was due to the weight gain if Claimant's weight gain was 30 to 40 lbs. rather than 110 lbs. CX-106, p.106.

Dr. Larsen opined that Claimant also needs knee replacement surgery. CX-106, p.63 Dr. Larsen testified that a knee replacement with someone such as Claimant weighing 350 lbs. would last "only a few years." CX-106, p.66.

Dr. Larsen's understanding of the mechanism of Claimant's industrial injury in 1987 is that Claimant "was walking when a top mobile crane hit him from behind on his knees and legs, knocking him down. And then the crane rested on top of him." CX-106, p.8. When the witness was shown CX-3, he changed his testimony to reflect the Long Beach paramedic emergency report that Claimant was crushed in his vehicle. CX-106, p.9

Dr. Larsen testified that Claimant needs to use hand crutches because he has difficulty walking as a result of his injury. CX-106, p.36. He also testified that a scooter is an appropriate means of transportation for Claimant, as long as he doesn't use it all of the time. CX-106, p.38. Claimant should walk as much as possible without crutches to keep his muscles strong. CX-106, p.39. Claimant can drive or be a passenger in a car according to pain allowing him to do so. The witness believes Claimant has pain medication available to him. CX-106, p.39. Dr. Larsen later testified that Claimant has trouble walking because of stiff and arthritic knees, that according to Claimant he uses the hand crutches 95 percent of the time, which Dr. Larsen finds reasonable. CX-106, p.57.

Dr. Larsen testified that Claimant did not miss work because of his prior knee problems before the industrial injury in 1987. CX-106, p.53. Claimant had knee surgery with Dr. Tepper in

1996 or 1997. Claimant weighed 345 lbs. when Dr. Larsen first saw him. and 320 lbs. when he was first admitted to St. Mary's after the 1987 accident.[38] CX-106, p.54-55. When shown CX-7, the witness stated that the record showed that Claimant weighed 250 lbs. when examined at St. Mary's on June 25, 1987.[39] CX-106, p.56.

Dr. Larsen opined throughout his testimony that because Claimant has not worked for 15 years, he doubts Claimant could compete "in the open marketplace" for work "ever again." CX-106, p.62. In addition, Claimant is not employable because of pain and the need for surgery. CX-106, p.68. Dr. Larsen also testified that Claimant cannot work because he is on narcotics [for pain] and therefore cannot drive or concentrate. CX-106, p.78.

Dr. Larsen testified that investigator Deline's testimony regarding observing Claimant sitting in his car and driving around the neighborhood is not inconsistent with Claimant's condition. CX-106, p.71.

Dr. Larsen testified that an EMG taken on July 10, 2002 found bilateral radiculopathies at L5 and S1 with prior chronic L3 or L4 radiculopathy consistent with "diabetes or other difficulties." CX-106, p.72. Dr. Larsen opined that this was caused by the industrial accident. Dr. Delgado is a radiologist who reviewed Claimant's recent MRI and found disc abnormalities and spinal stenosis at L3-4, L4-5 and L5-S1. Therefore Claimant needs surgery. CX-106, p.74-75.[40]

On cross-examination, Dr. Larsen testified that it is typical for patients to gain 100 lbs. when they reduce activity due to injury and eating more. CX-106, p.82. Dr. Larsen stated that he would not have an MRI done of Claimant's knee before performing total knee replacement. CX-106, p.85-86. He bases the decision on listening to the patient, performing a physical examination and looking at x-rays and medical records. The last x-rays done of Claimant's knees were on August 24, 1999. CX-106, p.86-87. The x-ray showed severe arthritic changes. Dr. Larsen also has information about the knee from Dr. Tepper's arthroscopy. CX-106, p.88. Some of Claimant's knee condition pre-dated the 1987 injury. Dr. Larsen is unsure of when he last did a knee range of motion study, but a range of motion study is not indicative of the need for total knee replacement and Dr. Larsen would do total knee replacement on someone with a normal knee range of motion. CX-106, p.89. Dr. Larsen testified that the reasons for total knee

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[38]The admitting report at St. Mary's Hospital on June 24, 1987 after the industrial accident states that Claimant had an "[e]stimated weight of 320 to 350 pounds." CX-1, p.1.

[39]The record was made on the second day of Claimant's admission at St. Mary's when Dr. Mizuguchi examined him and stated that Claimant was a "large person, 6'6" and weighing more than 250 lbs." CX-7, p.10.

[40]It is noted that in Dr. Larsen's December 12, 2002 report (CX-105, p.1490), he refers to "severe spinal stenosis" found by Dr. Delgado, whereas in his August 7, 2002 report (CX-105, p. 1479) Dr. Larsen paraphrases Dr. Delgado's review of the MRI by stating that Dr. Delgado "finds *mild* lateral recess stenosis at L3-4 and spinal stenosis secondary to disc bulges and hypertrophy at L4-5 and L5-S1." (italics mine)

replacement are "pain and degenerative disease responsible for it and limitation in function." CX-106, p.89.

Dr. Larsen admitted that he did not record the degrees of limited range of motion of the back in his reports. CX-106, p.93. He admitted that he did not think the MRI of disc bulging was "significant." CX-106, p.94. and that the disc material had not popped out of the casing, i.e., the disc bulges were "without frank herniation." CX-106, p.95. Dr. Larsen would perform a laminectomy to relieve pressure of the bulging discs on the nerve root.

Pertaining to the investigator's observation of Claimant sitting in his car, and whether Claimant could sit at a job, Dr. Larsen testified that Claimant's back problem does not affect sitting, rather it affects standing and walking. CX-106, p.100. Dr. Larsen stated he "believes" Claimant has trouble sitting too. He later testified that Claimant's surgery for separation of his open book pelvis fracture healed with significant scar tissue, making it difficult for Claimant to sit and to stand to get up from a chair and therefore this would affect Claimant's ability to work. CX-106, p.110.

After repeated questioning regarding Claimant's physical ability to sit for work, Dr. Larsen persisted in answering that Claimant could not work because he had not for the last 15 years, and would not answer the question directly. CX-106, p.103. Dr. Larsen would also not answer a question posed about Claimant's physical capacity to work part-time. Dr. Larsen testified that since Claimant is on social security disability, that means he cannot work. CX-106, p.104. Finally, Dr. Larsen did state that he was "not sure" whether Claimant could work part-time.[41] CX-106, p.104.

Dr. Larsen's Medical Reports

Dr. Larsen examined the Claimant seven times from August 24, 1999 to July 10, 2002. CX-92. During that period, his associate, Manuel Anel, M.D., examined Claimant on May 11, 2000. CX-92, p.1027. After the hearing on July 15 and 16, 2002, Dr. Larsen examined Claimant three times with the assistance of a physician's assistant, from July 29, 2002 to November 14, 2002. CX-105. During that period, his associate, Andrew Jarminski, M.D., examined Claimant twice. CX-105, p.1482, 1484. Dr. Larsen also prepared reports after reviewing Dr. Miller's medical reports, one on April 11, 2002, CX-101, p.1363, and one on December 12, 2002. CX-105, p.1490.

[41]In his report dated September 13, 2000, Dr. Larsen opines that Claimant is "unable to sit for more than three hours and is unable to stand or walk for longer than one hour, before he feels increased symptoms." CX-92, p.1021.

At Dr. Larsen's first examination of Claimant on August 24, 1999, CX-92, p.1099-1105, Dr. Larsen bases his diagnoses principally on Claimant's complaints:

1. Status post severe life-threatening traumatic injury with internal medicine complaints, status post surgery.

2. Bilateral knee complaints, right greater than left, status post surgery.

3. Spinal and pelvic complaints.

CX-92, p.1105. Dr. Larsen also states that Claimant is temporarily totally disabled on that date, with no apparent explanation.

Dr. Larsen's reports vary slightly from one examination to the next. The next exam on October 29, 1999 adds "buttock mass" to the same diagnosis. *Id.* at 1097. Dr. Larsen states Claimant remains temporarily totally disabled but gives no reason. On March 2, 2000, Dr. Larsen adds "status post buttock mass removal" to his diagnosis, and Claimant remains temporarily totally disabled with no apparent explanation. *Id.* at 1094. The diagnosis does not change on April 21, 2000. *Id.* at 1032. Dr. Anel adds to the diagnosis on May 11, 2000, "L4-5, L5-S1 disc bulging and degenerative disease." *Id.* at 1028. On June 12, 2000, Dr. Larsen gives Claimant the same diagnosis and continues to place him on temporary total disability. *Id.* at 1025. On September 13, 2000, in Dr. Larsen's "permanent and stationary" report, Claimant's diagnosis changes slightly, adding "internal medicinal plates" to paragraph 1, "spinal stenosis," and "pelvic complaints status post buttock mass removal." *Id.* at 1018. On July 10, 2002, Dr. Larsen's diagnosis remains the same, except for a change in the spelling, perhaps to correct typos, of "internal medicinal plates"to "internal medicine complaints." CX-105, p.1471. The diagnosis remains the same on July 29, 2002, *Id.* at 1475, but "lumbar stenosis" is added to the diagnosis on August 7, 2002, and Claimant is placed back on temporary total disability. *Id.* at 1479-1480. The remaining reports iterated above contain the same diagnosis. See CX-105, p.1482-1489.

In Dr. Larsen's two reports reviewing Dr. Miller's evaluations of Claimant, he states that Dr. Miller "in a characteristic fashion," CX-101, p.1366, minimizes Claimant's subjective complaints and objective findings. See *Id.* at 1366 and 1492-1493.

Testimony of David Eckhous:

Mr. Eckhous is an occupational therapist and orthotist. He was called by Claimant as a rebuttal witness at the hearing and by perpetuation deposition regarding his assessment of Claimant's functional capacity. In addition, Claimant submitted his report and it was admitted into evidence as CX-100.

Mr. Eckhous received a degree in occupational therapy from the University of Michigan and is registered as an occupational therapist. He has a certificate in orthotics from Northwestern University and training and certification in head orthotics. Tr.448. He is trained in prosthetics, but not certified. Tr.449.

Mr. Eckhous is not a vocational rehabilitation specialist. CX-107, p.64. His practice consists of 60 percent orthotics and 40 percent occupational therapy. One-third of his occupational practice is dedicated to the developmentally disabled. Most of the acute onset injuries he treats are of the extremities, not of the back. *Id.* at 61-62.

Rebuttal Testimony

Mr. Eckhous was called by Claimant to rebut Dr. Miller's testimony. Mr. Eckhous testified that he knows Dr. Miller from working with him at Rancho Los Amigos Hospital at which he attended Dr. Miller's clinics. Tr.449. Mr. Eckhous testified that Dr. Miller would see from 20 to 25 patients in an hour to an hour and 15 minutes, and that such exams were cursory and superficial. Tr.453-454.

Pepetuation Deposition Testimony

Mr. Eckhous testified at a deposition taken on July 10, 2002, which has been identified as CX-107. His testimony does not differ substantially from his report dated June 18, 2002 at CX-100; therefore, such report will not be summarized here.

The witness first met with Claimant at his attorney's office on May 28, 2002, CX-100, p.73, and formally evaluated him on April 3, 2002.[42] At that time he took an oral history of the accident and did a primary physical examination. He noted a loss of range of motion and strength in the upper extremities but indicated that Claimant could "manage his environment" with his arms. CX-107, p.14-15. He noted that Claimant's right lower extremity was more impaired than his left lower extremity, and that he could only flex his right knee to 35-45 degrees.[43] *Id*. at 15-16. You flex your knees to 90 degrees when you sit. Therefore Claimant has a third of the normal flexion range for sitting. *Id*. at 16-17. Mr. Eckhous testified that Claimant cannot sit continuously, *Id*. at 35, or for "great periods of time," because of his knee problem. *Id*. at 38. Mr. Eckhous testified on cross-examination that Claimant could sit for 2 hours with frequent posture changes to relieve the pressure on his distal right thigh. *Id*. at 72-73. When asked what his response would be to learn that Claimant had been observed sitting in his car for more than

[42]In his report at CX-100, p.1348, Mr. Eckhous states in contrast that he did *three* "hands-on" evaluations of Claimant, not two.

[43]Mr. Eckhous admitted on cross-examination that he had seen medical reports from Claimant's doctor (Dr. Larsen) that indicated Claimant had a greater range of motion in his right knee, i.e., 75-85 degrees of flexion. Mr. Eckhous testified that people can usually sit comfortably at 75 degrees of flexion. CX-107, p.74-75.

one hour, Mr. Eckhous testified he would be surprised, and would find it "incredible" if Claimant had sat in his car for 5 hours. *Id.* at 91.

Mr. Eckhous testified that Claimant has an antalgic or pain-induced gait, a "lumbering" gait. CX-107, p.12-13. The Veteran's Administration did a gait analysis, which reinforced Mr. Eckhous's thoughts.[44] Claimant is very "precarious" on uneven terrain. He can, however, walk on familiar, even terrain. He walked 50 plus yards in the parking lot. Steps and uneven surfaces cause fatigue. CX-107, p.31. Claimant needs crutches to aid him in ambulation and balance. *Id.* at 32. However, Claimant walked 20-25 feet without crutches in the office, *Id*. at 31, and Claimant told the witness that he does not use his crutches all of the time, he uses them "out in the community." *Id.* at 28. Claimant spends a large part of the day seated or recumbent. "He does drive a fair amount," and he goes to football games in the community which is tiring. *Id.* at 29. Mr. Eckhous testified that Claimant would not be "particularly safe" in a tight hallway or a bathroom due to the way he moves. In a hallway 36 inches across,[45] Claimant would block others trying to exit in an emergency due to his large size. On cross-examination, Mr. Eckhous admitted that people do work with crutches and canes in spite of the safety factor. "I have a lot of post-polio patients who use crutches for ambulation; and yes, they do work. It's not a problem." CX-107, p.93. On cross-examination, Mr. Eckhous stated that Claimant can stand and walk for a total of 40 plus minutes. *Id*. at 71.

Mr. Eckhous did no observational analyses of Claimant's abilities to do activities of daily living in the home, CX-107, p.26; rather, he interviewed Claimant and reported what he said. In addition, Mr. Eckhous admitted that his observations are based to a large extent on the patient's subjective response. "I have no idea what his pain tolerance or initiation point is." *Id*. at 72.

Mr. Eckhous testified that Claimant could stand for 20 minutes at a time during his evaluation. CX-107, p.31. Claimant could work at a job taking orders if he could sit frequently, and stand, walk and lift occasionally. *Id.* at 39-40. However, Claimant has a problem falling asleep, has trouble making appointments, and his ability to attend to a task is "spotty at best." *Id*. at 35, 40.

Mr. Eckhous testified that Claimant cannot lift objects because he uses crutches but he could place objects in a cart and roll it around. CX-107, p.39-40.

Mr. Eckhous believes that Claimant cannot work an 8-hour a day job. CX-107, p.34. In addition, Claimant would need custom furniture due to his large size. *Id*. at 36.

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[44]See CX-100, where the Veterans' Administration gait analysis is extensively quoted.

[45]Mr. Eckhous specified that this is the width of hallways under old construction standards. New construction specifies hallways of 60 inches in width under OSHA guidelines. CX-100, p.22.

Dr. Geoffrey Miller:

Dr. Geoffrey Miller testified on behalf of Employer. Dr. Miller is a board certified orthopedic surgeon and an associate clinical professor at University of California, Irvine. See, Curriculum Vitae of Dr. Miller, RX-71; Tr.105-106. Dr. Miller first examined Claimant on April 12, 1994 at the request of Employer's counsel. Dr. Miller's report from that examination is found at RX-48. On cross-examination, Dr. Miller admitted that he had not examined Claimant until seven years after the accident. He did review all of the medical records, or whatever was provided to him by counsel. Tr.171.

Dr. Miller testified that Claimant filled out an eight page personal history, which Dr. Miller then reviewed with him. Dr. Miller opined that based upon Claimant's history, he had sustained significant injuries on June 25, 1987, however, he did not characterize them as life threatening. On cross-examination, Dr. Miller was asked if he did not think a person who had suffered a fractured tibial plateau, a crushed pelvis and fractured transverse processes of the low back would experience residual complaints from such a serious injury. Dr. Miller opined, "Not necessarily." He explained that all three fractures healed in Claimant's case and if they had not healed, then perhaps. However, "just because they're fractures, of course, doesn't mean there's going to be pain." Tr.217-219. Dr. Miller's impression from Claimant at the time of his injury was that Claimant was working as a marine clerk, with "modest requirements," meaning little bending, stooping, lifting. It was not a "labor job." Tr.118-120.

Dr. Miller conducted a thorough physical exam of Claimant. At the time, Claimant weighed 350 pounds. Claimant had complained about pain in his cervical spine and shoulders, but Dr. Miller found Claimant had full range of motion in these two areas. Tr.122-123. Straight leg raising tests were negative both in the seated and supine position, signifying that there was no irritation of the nerves coming out of the spine. Dr. Miller qualified this as a "fairly normal exam." Tr.131. On cross-examination, Dr. Miller agreed that to some extent, straight leg raising test results depend upon a patient's tolerance for pain, but one would expect some response from the patient "because you're actually mechanically effecting their nerves more so than in the sitting and standing position." Tr.192-193. Claimant had flexion in his spine to 90 degrees, which again, Dr. Miller opined was normal. Dr. Miller opined that obese patients sometimes have difficulty with full flexion, but Claimant did not in spite of his weight. This indicated that Claimant was not suffering from a disc problem. Dr. Miller noted that Claimant had "fairly good" extension, explaining it was difficult to analyze with Claimant's crutches, but that he did not consider this an abnormal result. It did not merit any specific intervention. Tr.130-134.

Dr. Miller testified that Claimant suffered from congenital spinal stenosis, which is a narrowing of the spinal canal throughout. This condition had been present for a long time, and was not caused by the 1987 injury. He based this diagnosis on the CT scan performed on January 20, 1988. This condition may result in problems such as weakness and cramping in the legs. Tr.150-152. Dr. Miller testified that Claimant had undergone four or five imaging studies

between 1988 and 1994. None of these studies showed dramatic changes to Claimant's lumbar spine. Claimant had bulging, and degeneration, but no herniation, or pinching of the nerves, in any of the studies. Dr. Miller opined that a three-millimeter bulge, given his age, weight and prior low back injury in 1977, was not a surprising diagnosis. "It would be a surprise if there wasn't bulging." Tr.155-158.

Dr. Miller took films of Claimant's pelvis in 1994, and found that the plate in Claimant's pelvis was intact. This indicated that it was well-healed, and should not cause Claimant any problems, "because it remained solid with the repair." On cross-examination, Dr. Miller was asked how the pelvic fracture has affected Claimant's ability to walk. He responded that he did not think it had any significant effect. He continued, "the sacroiliac could have some effect, but it had healed, so therefore it is solid. So the weight bearing, the pelvis, although the patient may complain of some symptoms when walking, it would not have a major impact on walking unless the fracture went through the hip socket...which it did not." Tr.185. These x-rays also showed some early arthritic changes in Claimant's hips, which Dr. Miller opined were probably weight related for the most part, "but they go along with the knees, the hips and the back." Tr.160-163. See, RX-48, p.243.

Dr. Miller found no asymmetry in Claimant's thigh and calf circumferences, noting that this indicated there was not a problem with pinched or entrapped nerves. He detected no evidence of atrophy or of motor weakness. Dr. Miller observed Claimant walking without the aid of his crutches and noted that he was somewhat unsure of himself, but was able to bear weight symmetrically and walk across the room. Dr. Miller noted that ligament testing in the right knee was intact, indicating Claimant did not suffer from instability. Tr.134-136.

Dr. Miller testified that Claimant had indicated to him that he had suffered multiple fractures in his right knee. However, Dr. Miller opined that based on Claimant's x-rays, he did not suffer from multiple fractures in his knee. Dr. Miller noted that there was a lateral tibial plateau fracture of an indeterminate age found in an x-ray taken in July 1987, meaning that this was not a recent fracture. See, CX-25, p.36; Tr.139-140. Dr. Miller stated that he was aware that Claimant had prior right knee injuries. Dr. Miller had seen an x-ray from 1975, which indicated that Claimant suffered at that time from severe arthritis in his right knee. This x-ray also showed a fracture of the proximal fibula, indicating "some sort of traumatic insult to the knee," which may be a factor in the development of the arthritis. See, RX-42, p.224; Tr.141-144. Dr. Miller opined that due to Claimant's size, this arthritic condition will never improve. One can minimize its progression, but it will never be reversed. Tr.145.

Dr. Miller opined that based on this history, he would expect Claimant to have continuing problems with the knee. It would surprise him that Claimant would have been able to engage in strenuous activity including running, prior to the 1987 injury, as Claimant had testified to. He stated:

> It would surprise me not only because of the advanced nature of this arthritis but in '77 the left knee also had a problem and has some arthritic changes that are less, but does have arthritic changes. So then you're talking about a 300-plus pound man doing these things on two knees that have arthritis, and that would be difficult.
> Tr.146.

Dr. Miller opined that Claimant's request for a transfer to the clerk's union in 1980 would be consistent with the 1977 x-rays, as well as the types of problems he would expect to see Claimant suffering from in 1980. Tr.149.

Dr. Miller reported that he could not find any reason why Claimant would need to use crutches. Tr.164. Dr. Miller stated, after observing Claimant in the courtroom, that he has right knee flexion to 70 to 80 degrees, which did not vary from his last evaluation of Claimant. This flexion would not be any real detriment to Claimant's ability to sit for extended periods of time, nor to drive a car. Tr.241-243.

Dr. Miller found Claimant permanent and stationary and precluded him from work that involved prolonged standing or walking because of the right knee, no stooping or repetitive bending because of the low back, and no heavy lifting, based on the combination of Claimant's condition. Dr. Miller felt that at this time in 1994, Claimant could work an eight hour day, following these restrictions. Dr. Miller thought Claimant was capable of working as a marine clerk, or similar sedentary-type work. Noting that at the hearing, Claimant had been sitting in court from 10:00 a.m. to 3:00 p.m. with an hour break for lunch, that this would be consistent with his work recommendations, "particularly since this chair is not ergonomic." Tr.164-166.

Dr. Miller examined Claimant again in 1995 and 1999. He stated that Claimant's condition had not changed in any significant way. He did review additional medical records and imaging studies, but found Claimant to be "essentially the same as when [he] first saw him in 1994." Tr.167. See, RX-52 and RX-55.

After the hearing, Dr. Miller examined Claimant again on November 17, 2002. That exhibit has been marked and admitted as RX-79. Dr. Miller examined additional medical records of Claimant at that time, as well as conducting a full interview and physical examination of Claimant.[46] Dr. Miller stated in his report that Claimant was "really no different" since the

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[46]Dr. Miller stated that Claimant had referred to exploratory hip surgery, for which Dr. Miller had seen no record. Apparently, this refers to the cyst removed on November 16, 1999. CX-95, p.1193. .

examinations Dr. Miller had conducted in 1995 and 1999. RX-79, p.6. Of note, Dr. Miller found the mid-thighs and the calves to measure the same, whereas the two knees measured one and one-half inches greater on the right. He also observed Claimant flexing his right knee to 90 degrees while getting off of the examining chair whereas on direct examination, Claimant only flexed the right knee to 45-60 degrees, with full extension. RX-79, p.4. Dr. Miller opined that Claimant's true range of motion is probably closer to 70 to 80 degrees, consistent with other medical records from 1996 t0 1997 where the orthopedic surgeons were able to achieve up to 70 degrees of motion after manipulation and more during the operative procedures. *Id*. at 7. In addition, Claimant was able to flex his back to 90 degrees with the use of his crutches, whereas he had more of a problem with extension. *Id*. at 4. Dr. Miller opined that Claimant's leg symptoms were due to his diabetic peripheral neuropathy, not a lumbar spine disorder since the MRI showed degeneration without nerve entrapment. *Id*. at 6.

Medical Records:

The parties submitted medical records dating back to the date of injury, June 27, 1987. There are thousands of pages of medical records before the Court. A summary of the relevant records follows:

Reports of Dr. Eric Feldman:

The report dated February November 4, 1988 shows that Claimant's past medical history was "significant for obesity." Claimant had a history of right knee trauma and osteoarthritis, history of sleep apnea syndrome, and premature ventricular contractions. Claimant smoked one and a half packs of cigarettes a day. Claimant had a "biomechanical dysfunction that is significantly influenced by his obesity and deconditioning." Dr. Feldman continued: "He is not a medication abuse problem, but certainly I think significant operant behavior along with questionable motivation and unknown secondary gains with continued litigation can effect this nice gentleman's problem." Dr. Feldman suggested a pain management program and occupational therapy. RX-4, p.47-49.

In his report dated March 11, 1991, Dr. Feldman noted that Claimant had lost 27 pounds while in the hospital, but was having trouble losing any more weight. He stated that Claimant had not returned to work because his restrictions had not been proper delineated, but that he thought Claimant could return to sedentary work with no repeated bending, stooping or lifting, with "frequent breaks as far as standing to sitting alteration." RX-20, p.98.

Reports by Dr. Douglas Jackson:

On February 27, 1990, Dr. Jackson reported that Claimant had not yet reduced his weight enough to undergo right knee surgery. The goal was to reach 200 pounds. RX-8, p.73. On June 1, 1990, Dr. Jackson reported that Claimant had reached permanent and stationary status and was unable to return to his prior work. He had reached this status because "based on his past history

and the sequelae since his injury, that it is unlikely he will ever obtain the weight loss desired to consider major knee surgery." Claimant's "pre-existing obesity contributed to the marked disability and morbidity that were associated with his significant injury." Dr. Jackson stated that Claimant was capable of "selected types of sedentary work and must rest and have position changes as necessary." RX-9, p.74.

In a report dated March 8, 1991, Dr. Jackson stated that Claimant's x-rays of his right knee showed significantly advanced degenerative changes. Dr. Jackson felt that arthroscopic surgery would cause more of a setback, rather than helping with his pain and range of motion. Dr. Jackson thought it an excellent idea the Claimant return to work because "he is going to have trouble whether he is at work or not at work." RX-18, p.96.

Reports by Dr. Fred Batkin:

Dr. Batkin treated Claimant for approximately six weeks in a pain management clinic. In a report dated January 3, 1991, Dr. Batkin noted Claimant had improved range of motion in his right knee, from 35 degrees when he began the program, to 65 degrees passive and 55 degrees active as of December 28, 1990, the date of the examination. He had improved strength and functional tolerances and was able to carry 10 pounds for 400 feet. Claimant could stand for 45 minutes and sit for 1 ½ hours. Claimant had lost 17 pounds and was down to 350 pounds. RX-11, p.78.

In a report dated January 4, 1991, Dr. Batkin reported Claimant had successfully completed his pain management program. Claimant had shown marked improvement in functional tolerances, strength, endurance and application of proper body mechanics. Claimant had told Dr. Batkin that his back and right knee problems had "significantly improved." Dr. Batkin reported that Claimant had "several job possibilities located in the harbor," all sedentary positions. Dr. Batkin recommended a drafting stool with back support for working at a high counter. Dr. Batkin found Claimant permanent and stationary and released him to sedentary work as of January 14, 1991, with the following restrictions: no repetitive lifting over 20 pounds, no prolonged standing or walking. RX-12, p.80-81.

Reports of Dr. Stanford Noel:

Claimant was referred to Dr. Noel for his hip pain, by Drs. Feldman and Jackson. In a report dated March 1, 1991, Dr. Noel stated that he felt Claimant was capable of sedentary work as long as he could change positions, but he might have some difficulty sitting due to his radicular symptoms. RX-17, p.95. In a report dated May 7, 1991, Dr. Noel reported that he had reviewed an MRI of Claimant's low back. He found degenerative changes at L4-5 and L5-S1. Claimant had mild right L5 radiculopathy based on an EMG conducted on March 4, 1991. Dr. Noel recommended epidural injections for Claimant's pain. At this time, Dr. Noel adopted Dr. Batkin's restrictions in his January 14, 1991 report, specifically, sedentary work, no lifting greater than 20 pounds, and no prolonged standing or walking. RX-21, p.100.

In a report dated September 9, 1991, Dr. Noel reported that Claimant had tried to work as a marine clerk. He sat in a chair, but "couldn't handle it." Dr. Noel cleared Claimant for sedentary work, with no lifting, twisting or turning. RX-23, p.102. In a report dated December 12, 1991, Dr. Noel again released Claimant to sedentary work with the same restrictions. He found straight leg raising both actively and passively to 90 degrees bilaterally, and limited flexion of 45 degrees in his right knee, but strong active extension associated with marked crepitus in the knee. Dr. Noel stated that Claimant is "obviously morbidly obese and would benefit from weight loss although this is unrelated to his industrial injury." RX-24, p.106-108.

In a report dated January 23, 1992, Dr. Noel again stated that he felt Claimant was capable of sedentary work on a regular basis, after retraining. RX-25, p.110. In his report dated May 8, 1992, Dr. Noel stated that Claimant had failed to attend his rehabilitation testing sessions regularly, and when he did attend, he had a tendency to be inattentive. Claimant aggressively requested that Dr. Noel operate on his right knee, which Dr. Noel explained was not the proper course of action in Claimant's obese condition. Claimant stated that he would find someone who would operate on him. Dr. Noel continued that Claimant "has been unwilling to accept his disability and accept responsibility for his own life. He is manipulative and I do not desire to be further used in this fashion." RX-27, p.112-113.

In Dr. Noel's final report, he stated that Claimant was "obviously attempting to maximize his symptoms." Dr. Noel stated that Claimant had fabricated certain comments and was "manipulating various parties." He did agree to authorize another course of epidural injections as Claimant did have "objective evidence of long-standing abnormality on the low back." However, Dr. Noel continued:

> Considering all of the factors outlined above, I do not believe that [Claimant] is a good candidate for any sort of retraining program. He remains severely obese and has used a variety of complaints and requests in his effort to avoid active exercise or retraining programs. . . . Some of his comments are clearly fabricated. I would again note that in my opinion based on the various visits, studies, and extensive records, I believe he is capable of sedentary work as noted in my report of December 12, 1991. However, it appears that he will utilize all efforts to avoid returning to any sort of work, and I do not know of any method to motivate him to do so.
>
> RX-28, p.115-226.

Reports of Dr. James T. London:

Dr. London performed an extensive evaluation of Claimant On July 26, 1991. He reviewed Claimant's medical records and took a thorough history. In a report dated November 5, 1991, Dr. London opined that Claimant had become permanent and stationary as of June 1, 1990.

He further opined that Claimant had recovered from the injuries he had sustained to his cervical, thoracic and lumbar spine "without evidence of permanent disability." He found that Claimant suffered from a 20 percent impairment of his right lower extremity as a result of the injuries sustained to his right knee and right hip. Dr. London released Claimant to work with the following restrictions: no prolonged standing or walking, repeated climbing, squatting, kneeling or crawling, or repeated bending or stooping. Dr. London further opined that:

> the pre-existing lumbar disc disease, the pre-existing arthritis in the hips and knees, and the prior injuries produced permanent disability that was present prior to the industrial injury of June 25, 1987. The pre-existing disability in [Claimant's] lumbar spine and the pre-existing disability in his hips and knees combines with the disability that results from the June 25, 1987 injury to produce a greater total disability than would have been present absent these prior injuries and prior conditions. RX-4, p.51-68.

In a report dated December 21, 1993, Dr. London stated that he had attempted to re-evaluate Claimant, but he was accompanied by two people who carried on conversations with Claimant throughout the exam. Claimant was uncooperative, evasive, and unresponsive. Dr. London noted: "I indicated to [Claimant] that he should attempt to be cooperative in responding to my questions so that I could perform a meaningful consultation. [Claimant] indicated that I was a fool. At that point, I terminated the exam and asked him to leave." RX-33, p.138-139.

Vocational Evidence:

On May 31, 1991, a vocational evaluation of Claimant was preformed by Rochelle Cafferty at Shoreline Assessment & Rehabilitation Services. At that time Claimant informed her that his doctors had taken him off permanent and stationary status and that they did not think Claimant would be capable of working for at least eight months. Claimant stated that a recent MRI indicated that he had severe nerve damage and arthritic changes in his spine, and required surgery or injections. Ms. Cafferty found that Claimant was capable of sitting for 1 to 1 ½ hours and could stand and drive a car for the same period of time. He was more comfortable sitting in a high stool rather than a chair. Ms. Cafferty needed clarification of Claimant's medical status in order to proceed with finding suitable alternate employment. RX-34, p.140-148.

In a letter dated January 31, 1992, Ms. Cafferty reported that Claimant had told her that he wished to return to work, and that he thought he was capable of performing a number of jobs on the docks, namely dispatcher at 247, outgate, supercargo clerk on coal, ash, and rail cars, or supercargo on passenger ships. RX-35, p.149.

On April 23, 1993, Dr. London authored a letter to Ms. Cafferty, in which he stated that he had reviewed the job requirements for a sedentary marine clerk position. Dr. London opined that this type of work was appropriate for Claimant. RX-30, p.118. In a letter dated June 1,

1993, Dr. London reviewed a series of job descriptions including customer relations representative for Long Beach Nissan Mart, auto presenter for Moon Nissan, customer service representative for Federal Warranty, and order taker for National Marketing, service cashier for Cormier Chevrolet, receptionist for J.D. Towing, manager for Long Beach Self Storage and dispatcher for Continental Cablevision. Based upon a review of Claimant's medical records, Dr. London approved all of these jobs as within his physical capabilities. RX-31, p.119-132.

On May 28, 1993, Ms. Cafferty submitted a report of her research regarding suitable alternate employment. Ms. Cafferty conducted a telephone survey of potential employers in order to determine the essential job functions and qualifications required to perform the jobs. All the jobs investigated were for sedentary work. Ms Cafferty found eight available jobs that met the restrictions placed on Claimant: order taker, one position available; service cashier, one position available; customer relations / service, three positions available; self storage manager, one position available; dispatcher, two positions available. The salaries ranged from $6.50 to $12.00 per hour. All of these positions allowed for a person to sit frequently to constantly, with the opportunity to stand or walk for personal comfort. RX-37, p.152-159.

On August 2, 1999, Ms. Randi Langford Hetrick conducted another labor market survey, and identified nine jobs that fit Claimant's restrictions, including telemarketing, appointment setting, desk/customer service, and cashier positions, all of which were sedentary or semi-sedentary entry-level positions. See, RX-61, 62. On September 3, 1999, Dr. Miller reviewed the report and job descriptions for Claimant. See, RX-56, p.308. Given his physical findings, Dr. Miller found that all of the jobs in that report were acceptable for Claimant. Tr.169. Ms. Hetrick completed another labor market survey on April 18, 2001, locating jobs within Claimant's restrictions, including telemarketing, telephone surveyor, order desk clerk, and appointment setter. All of the jobs are sedentary, with occasional standing; only one job requires occasional walking. RX-66. The occupational forms for these jobs were forwarded to Dr. Miller who approved them as meeting Claimant's restrictions. RX-73.

ANALYSIS

I. Maximum Medical Improvement:

An injured worker's impairment is deemed permanent if the condition has reached maximum medical improvement or if the impairment has continued for a lengthy period of time and appears to be of a lasting duration. *Watson v. Gulf Stevedoring Corp.,* 400 F.2d 649, 654 (5th Cir. 1968), *cert. denied,* 394 U.S. 976 (1969); *James v. Pate Stevedoring Co.,* 22 BRBS 271 (1989). "Maximum medical improvement" and "permanent and stationary" are legal concepts developed in case law to ascertain when a claimant's condition has moved from a temporary to a permanent status.

Permanency does not, however, mean unchanging. Permanency can be found even if there

is a remote or hypothetical possibility that the employee's condition may improve at some future date. *Watson*, 400 F.2d at 654; *Mills v. Marine Repair Serv.*, 21 BRBS 115, 117 (1988). Likewise, a prognosis stating that the chances of improvement are remote is sufficient to support a finding that a claimant's disability is permanent. *Walsh v. Vappi Constr. Co.*, 13 BRBS 442, 445 (1981); *Johnson v. Treyja, Inc.*, 5 BRBS 464, 468 (1977).

The date a claimant's condition becomes permanent is a question of fact to be determined by the medical evidence and not by economic or vocational factors. Thus, the medical evidence must establish the date on which the claimant has received the maximum benefit of medical treatment such that his condition is not expected to improve. See *Trask*, 17 BRBS at 60; *Mason v. Bender Welding & Mach. Co.*, 16 BRBS 307, 309 (1984).

Claimant did not address the issue of maximum medical improvement in his Post-Trial Brief. Employer however, argues that Claimant reached maximum medical improvement by June 1, 1990, based upon the permanent and stationary report of Claimant's treating physician, Dr. Jackson. RX-9, p.74. Dr. Miller concurred with this finding in a report dated April 22, 1994. RX-48, p.252. Dr. London concurred as well, in his comprehensive report dated November 5, 1991. RX-4, p.65. After careful review of the reports, I find that the medical evidence, including the report by Claimant's treating physician at the time, Dr. Jackson, establishes that Claimant was permanent and stationary by June 1, 1990. Thus, I find that Claimant reached maximum medical improvement as of June 1, 1990.

II. Nature and Extent of Claimant's Injuries:

Credibility Findings

The Claimant

There are multiple indications in the record of Claimant's lack of credibility. The most recent one occurred at trial. Claimant testified that he was currently taking 500 or 750 milligrams of Vicodin per day and further testified that his prescription for Vicodin had been refilled as late as February of 2002. Tr. 258, 318, 398, 440-444. On cross-examination, he was not able to produce any evidence corroborating this testimony, even after he was allowed to return home on two occasions to find such prescription or a container verifying such prescription which, he testified, were at his home. He was only able to produce a container which was over a year old.

Claimant's lack of credibility was further demonstrated at the hearing. A review of the deposition of David Eckhous, the occupational therapist/orthotist called by Claimant as a witness, revealed that Claimant told Mr. Eckhous that he had a very limited sitting tolerance, i.e., less than a half hour at a time. Contrary to that representation, Mr. Luke sat at the counsel table and in the

witness box for extended periods of time, e.g., up to 2 hours continuously, without any apparent discomfort or need to change positions. Not only did Claimant's behavior in the Courtroom invalidate any opinions voiced by Mr. Eckhous on Claimant's ability to perform sedentary work, Claimant's behavior also suggests that he was not entirely candid when questioned about his physical capabilities.[47]

In addition, Claimant seemed fully capable of sitting at the counsel table and working crossword puzzles during the course of the hearing, yet Claimant indicated on the witness stand that he could not read material presented to him because of a lack of eyeglasses. Tr.48.

The trial record contains additional evidence of Claimant's lack of credibility. For example, at trial, Claimant described a sleep problem which, he asserted, developed subsequent to this industrial injury; he specifically denied having any similar problem prior to that date. Claimant's medical records, however, indicate otherwise. In a consultation with a Dr. Hamood on July 16, 1987, less than a month after the subject injury, Claimant gave a history of "falling asleep very easily at any time, day or night, voluntarily and involuntarily . . . . for a prolonged period of time." CX-35, p.45. Then, in a consultation with Dr. Fotinakes on July 20, 1987, Claimant also related a long history of such sleep problems indicating that, in the past, there had been several occasions when it was necessary for him to pull off the road while driving to sleep, and that he often took naps at work in his car, usually requiring someone to come and wake him up. CX-36, p.46. As Claimant would not have been driving or working between the time of his injury and those consultations, it is clear that this was a problem that pre-existed the industrial accident, yet at trial, Claimant asserted that this problem did not exist prior to it. Tr.63-64.

Claimant testified under oath that he weighed approximately 295 pounds at the time of the occupational injury, Tr.345, and that, at one point after the accident, he weighed as much as 390 pounds. Tr.347. However, his medical records, once again, indicate otherwise. A review of those records reflects that Claimant's weight has consistently been reported as being approximately 350 pounds, from the time of his initial hospitalization, CX-1, p.1; CX-38, p.52 (320-350 lbs.), through the dates of his exams last year. CX-65, p.161 (1/22/88, 335lbs.); CX-82, p.324 (11/26/90, 343 lbs.), 326 (1/3/91, 350 lbs.); CX-90, p.391 (8/4/93, 355 lbs.); CX-102, p.1377, 1425 (5/14/97, 350 lbs.); CX-92, p.1099 (8/24/99, 345 lbs.); CX-94, p.1128 (10/14/99, 350 lbs.); CX-95, p.1147 (11/1/99, 350 lbs).; CX-98, p.1303 (1/31/01, 360 lbs.). While it may not be unusual for people to lie about their weight, credibility even on this subject should be expected under oath.

Furthermore, Claimant admitted that his weight had gone from a low of 245 pounds to at least 295 pounds by the time of this accident Tr.345, despite the fact that he claimed to have been

[47]Claimant's ease in sitting at the hearing at the counsel table and in the witness box would also seem to invalidate Mr. Eckhous' opinion that Claimant might need specially designed furniture to work in an office setting. Certainly, the furniture used by Claimant in the Courtroom was far less comfortable and forgiving than that which would be found in most offices.

very physically active prior to that time. He could not really explain that significant weight gain, which would even be more significant if it went from 245 to 350, rather than 295. The inference can be drawn that Claimant was not very active even before this incident, likely because of his admitted pre-existing right knee problems which Claimant admits was the partial cause of his applying for admission to the Marine Clerk's Union in 1980. Tr.47.

Claimant's lack of credibility is also evident in the reports and deposition of Dr. Noel. RX-27, 28, 29 and 41. Dr. Noel described the Claimant as "manipulative." RX-27, p.113. Dr. Noel specifically noted that claimant was "obviously attempting to maximize his symptoms" and, further, believed that Claimant had "used a variety of complaints and requests in his effort to avoid active exercise or retraining programs," additionally stating that some of Claimant's "comments are clearly fabricated," and that it appeared that Claimant would "utilize all efforts to avoid returning to any sort of work." RX-28, p.115, 116. Dr. Noel testified in his deposition that Claimant "fabricated information" and "was not truthful" and that it was his impression Claimant "was trying to convince me that he had the most severe degree of symptoms that I would believe." RX-41, p.207-209. As Claimant was referred to Dr. Noel by his then treating physician Dr. Jackson, RX-41, p.193-194, Dr. Noel has no motive for bias against Claimant; thus, his comments regarding Claimant are credible.

Dr. Noel was not alone in questioning Claimant's motivation. One of Claimant's earlier treating physicians, Dr. Feldman described what he called "significant operant behavior along with questionable motivation and unknown secondary gains...." CX-65, p.147.

In light of this evidence, there is ample reason to doubt Claimant's credibility, especially in describing his physical condition. Claimant's subjective statements as to his inability to work, therefore, are given little weight. In addition, this calls into question doctors' opinions which rely on Claimant's subjective complaints.

Dr. Larsen

Dr. Larsen's testimony and medical reports reflect repeated inaccuracies and inconsistencies which call into question the reliability of his findings and conclusions. Dr. Larsen first saw Claimant twelve years after the date of the subject occupational injury. CX-106, p.7. Dr. Larsen acknowledged that Claimant's initial medical history was taken by a member of his staff and later reviewed by him. RX 70, p. 431. Dr. Larsen did not initially obtain a correct account of the subject industrial incident. RX-70, p.432-33. And at the time of his initial evaluation of Claimant, Dr. Larsen was also not aware of Claimant's prior history of football injury to his knees and prior knee surgeries. RX-70, p.453-454. Dr. Larsen acknowledged in testimony that he believed Claimant had atrophy in the lower extremities despite a lack of findings to support this and despite the fact that he did not recall performing an objective test for weakness. RX-70, p.444-46.

Dr. Larsen opined that Claimant needs mechanical assistance in ambulation despite the fact that no other physicians prescribed such devices.[48] RX 70, p. 469-70. The doctor testified that Claimant needs hand crutches, CX-106, p.36, and a scooter, CX-106, p.38, for ambulatory assistance due to alleged atrophy and weakness of the lower extremities. At the same time, Dr. Larsen stated that he would not want Claimant to use a scooter "all the time because it would lead to further weakness and atrophy." and that he would want Claimant to walk as much as possible without crutches to keep his muscles strong. CX-106, p.38-39.

However, in later testimony on November 1, 2002, Dr. Larsen stated that Claimant was using his crutches "about 95% of the time to get around" and that this was reasonable. CX-106, p.57-58. Dr. Larsen also testified that, upon recent examination, he had found Claimant's knees to be stiff and arthritic. CX-106, p.57. However, when Dr. Miller examined Claimant on October 30, 2002, Claimant reported that his left knee was "ok" and that the right knee was stiff but without any pain, swelling, buckling or locking. RX-79, p.3. Furthermore, Dr. Miller found on physical examination range of motion close to 70 to 80 degrees on the right knee, RX-79, p.7, and 120 degrees with full extension on the left. RX-79, p.4.

Dr. Larsen's testimony and report findings reflect a bias in favor of Claimant's self-serving complaints. Dr. Larsen clearly has accepted Claimant's pain complaints at face value, RX-70, p.451, and has made conclusive medical statements not supported by objective findings. For example, Dr. Larsen has repeatedly recommended that Claimant have additional surgeries -- laminectomies of L3 to S1 and knee replacement, CX-106, p.59, 63, despite the serious risk to Claimant due to his diabetes, circulatory problems, and morbid obesity, and despite the fact that all other surgeons offering an opinion on this subject have recommended against additional surgery. Dr. Miller recommended no additional surgery because the objective tests do not demonstrate significant nerve entrapment to warrant lumbar surgery and the neurological tests show that the lower extremity symptoms are due to diabetic peripheral neuropathy. RX-79, p.6, 7.

In addition to Dr. Miller's recommendation against further knee surgeries, Dr. Jackson recommended against knee surgery unless Claimant's weight was close to 200 pounds. RX-8, p.73. Dr. Noel also stated that Claimant was not a good candidate for knee replacement surgery. RX-27, p.113. Even Dr. Larsen, who would perform the knee replacement surgery, acknowledged that a knee replacement would last only a few years. CX-106, p.66. Dr. Larsen also revealed in recent testimony that he would proceed with a total knee replacement based on the Claimant's complaints and desire to have the procedure and without first performing an MRI because "I know what we're going to find." CX-106, p.85. At the same time, Dr. Larsen admitted that, although he could not remember when he last performed a range of motion test on Claimant's knees, he would perform knee replacement surgery on an individual with normal range of motion. CX-106, p.89.

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[48]Dr. Larsen testified that Dr. Fonseca had stated "he [Claimant] requires the use of crutches for ambulation." RX-70, p.469. Dr. Fonseca's August 3, 1993 report at CX-90 contains no such recommendation.

At the conclusion of Dr. Larsen's perpetuation deposition, the doctor stated that Claimant could never return to work even after successful surgeries to relieve his pain and improve his function because of "psychosocial" factors and because, "I think that people who are made to go through long legal battles like Mr. Luke has been forced to go through develop changes in their self-esteem . . . and confidence in going back to work. I think that's a big factor." CX-106, p.97. These statements by Dr. Larsen reveal a non-medical bias in favor of Claimant in the context of this litigation and therefore, Dr. Larsen's medical opinions are accorded little evidentiary weight.

Legal Analysis

The burden of proving the nature and extent of disability rests with the claimant. *Trask v. Lockheed Shipbuilding Constr. Co.*, 17 BRBS 56, 58 (1980). Disability is generally addressed in terms of its nature (permanent or temporary) and its extent (partial or total). As already stated above, Claimant's condition became permanent on June 1, 1990. Thus, the issue in dispute is the extent of disability, or whether Claimant's disability is total or partial. The Act defines disability as an "incapacity to earn the wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Therefore, the claimant must demonstrate an economic loss in conjunction with a physical or psychological impairment in order to receive a disability award. *Sproull v. Stevedoring Service of America*, 25 BRBS 100, 110 (1991). Thus, a disability requires a causal connection between a worker's physical injury and his inability to obtain work.

In cases such as this involving disputes over an injured worker's post-injury wage-earning capacity, the burden is initially on the claimant to show that he cannot return to his regular employment due to his work-related injury. *Bumble Bee Seafoods v. Director, OWCP*, 629 F.2d 1327 (9th Cir. 1980); *Trask v. Lockheed Shipbuilding Co.*, 17 BRBS 56, 59 (1980). If it is shown that a claimant cannot return to his past job due to a work-related injury, the claimant is presumed to be totally disabled unless the employer is able to successfully demonstrate the existence of suitable alternate employment for the claimant in the geographical area where the claimant resides. *See, e.g., Bumble Bee* , 629 F.2d at 1327; *Hairston v. Todd Shipyards Corp.*, 849 F.2d 1194 (9th Cir. 1988). To satisfy its burden of showing suitable alternate employment, the employer must point to specific jobs that the claimant can perform. *Bumble Bee*, 629 F.2d at 1330. In addition, when considering whether a proposed job is suitable for a claimant, a factfinder must also consider the claimant's technical and verbal skills, as well as the likelihood that a person of the claimant's age, education, and employment background would be hired if he or she diligently sought the proposed job. *Hairston*, 849 F.2d at 1196; *Stevens v. Director, OWCP*, 909 F.2d 1256, 1258 (9th Cir. 1990), *cert. denied*, 498 U.S. 1073 (1991).

If the employer makes the requisite showing of suitable alternate employment, a claimant may rebut the employer's showing, and thus retain entitlement to total disability benefits, by demonstrating that he diligently tried to obtain such work, but was unsuccessful. *Edwards v. Director, OWCP*, 999 F.2d 1374, 1376 n.2 (9th Cir. 1993), *cert. denied*, 511 U.S. 1031 (1994); *Palombo v. Director, OWCP*, 937 F.2d 70 (2nd Cir. 1991); *Newport News Shipbuilding and Dry*

Dock Company v. Tann, 841 F.2d 540, 542 (4th Cir. 1988); *Roger's Terminal & Shipping Corp. v. Director, OWCP*, 784 F.2d 687, 691 (5th Cir. 1986), *cert. denied*, 479 U.S. 826 (1986).

In the instant case, Claimant denies the ability to return to any work whatsoever. Claimant's treating physician, Dr. Larsen has found Claimant to be permanently and totally disabled. Employer concedes that Claimant cannot return to his past job on the waterfront.[49] However, Employer asserts that Claimant is capable of sedentary work and that the evidence shows that there are jobs available within Claimant's geographical area that meet the criteria for sedentary work, thus making the requisite showing of suitable alternate employment.

In arriving at a decision in this matter, it is well-settled that the fact-finder is entitled to determine the credibility of the witnesses, to weigh the evidence, and draw her own inferences from it, and she is not bound to accept the opinion or theory of any particular medical examiner. *Todd Shipyards v. Donovan*, 300 F.2d 741 (5th Cir. 1962); *Bank v. Chicago Grain Trimmers Ass'n, Inc*., 390 U.S. 459, 467, *reh'g denied*, 391 U.S. 929 (1968). I am unconvinced by Claimant's testimony as a whole, and thus cannot rely on his testimony as proof of the extent of his disability. I find many discrepancies in Claimant's testimony, as well as important omissions on his part, which lead the undersigned to conclude that Claimant is not a credible witness.

The undersigned has disregarded Claimant's testimony as proof of the severity of his injuries. What is left then, is the testimony of the parties' medical experts.[50] Because I give more credence to Employer's experts and to former treating physicians of Claimant on the issue of Claimant's physical injuries and limitations than I do his current treating physician, I find that the evidence shows that Claimant is permanently partially disabled and is capable of sedentary work. Furthermore, Employer has successfully made the requisite showing for suitable alternate employment.

When considering medical evidence concerning a worker's injury, a treating physician's opinion is entitled to "special weight." *Amos v. Director, OWCP*, 153 F.3d 1051 (9th Cir. 1998). However, a treating doctor's opinion is not necessarily conclusive regarding a claimant's physical condition or the extent of his disability. See *Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989); *Amos*, 153 F.3d at 1054 ("special weight" standard limited to treating doctor's opinion regarding treatment). Moreover, the court may reject the opinion of a treating physician which conflicts with the opinion of an examining physician, if the decision sets forth "specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Magallanes*, 881 F.2d at 751.

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[49]See p.11-12, ALJX-4.

[50]I do not consider Mr. Eckhous to be a medical expert and therefore his testimony has minor probative weight, particularly since he admitted that he relied on Claimant's subjective complaints to make his findings.

The Court must reject Dr. Larsen's opinion of Claimant's disability, as he relied heavily on Claimant's unsupported subjective representations of his symptoms, which are not substantiated by the objective findings. Furthermore, the Court notes several deficiencies in Dr. Larsen's reports. Dr. Larsen operated under a misunderstanding of the mechanism of injury, his reports are filled with inaccurate information furnished by Claimant, and he was unaware that his patient had suffered from pre-existing injuries to his knees. In contrast, Dr. Noel, Dr. Miller, Dr. London, Dr. Batkin and Dr. Fonseca's conclusions are based on accurate information, objective findings, and the full picture of Claimant's medical condition both before and following the June 27, 1987 injury. They are detailed and thorough in their analysis of Claimant's condition. Therefore, the undersigned finds these opinions well-reasoned and more persuasive than Dr. Larsen's. Taking these opinions into account, I find that Claimant's work limitations are as follows: sedentary work (Drs. Feldman, Batkin, Noel, and by inference, Drs. Miller and London) with no prolonged standing or walking (Drs. Miller, Batkin, Noel, and London), no stooping (Drs. Miller, Feldman, and London), no repetitive bending (Drs. Miller, Feldman, and London), no heavy lifting (Drs. Miller, Feldman, Batkin and Noel: no lifting over 20 pounds); no repeated climbing, squatting, kneeling or crawling (Dr. London).[51]

Respondents acknowledge that it cannot be estimated how many hours Claimant would have been able to work as a marine clerk or what he could have earned because some marine clerk jobs may not have been available to him. ALJX-4, p.12. Therefore, Employer has not met its burden to show suitable alternate employment in the marine clerk category, nor has it been able to rebut Claimant's contention that he cannot return to his pre-injury employment. Thus, Claimant is permanently totally disabled from June 1, 1990 until to February 8, 1993, when Employer met its burden to show that Claimant could perform suitable alternate employment. Thus, Claimant is permanently partially disabled as of the date the first suitable alternate employment was located on February 9, 1993, a job as a dispatcher at Continental Cable Vision. RX-37, p.156. That position, as well as another dispatcher position, and positions as order taker, cashier, customer service clerk, self storage manager were identified in a labor market survey prepared by Rochelle Cafferty on May 28, 1993. RX-37.

Ms. Cafferty reported the wage equivalent for these jobs for 1987, the year Claimant suffered his industrial injury. Averaging the wages for all five types of job, the range is $6.20 to $7.00 per hour. Thus, the suitable alternate employment identified would pay Claimant an average hourly rate of $6.60. Multiplying $6.60 times 40 (a work week) yields a weekly wage of $264.00. Subtracting $264.00 from Claimant's average weekly wage of $1681.37[52] yields $1417.37. Two-thirds of $1417.37 is $944.96 which is Claimant's entitlement to compensation but for Section 6(b) of the Act which mandates a national maximum. Section 6(b) of the Act limits a claimant's compensation for disability to 200 percent of the applicable national average

[51]In his deposition at RX-70, p.25-26, even Dr. Larsen agreed that "[a]bsent pain, he [Claimant] could probably work sedentary."

[52]Per Section 8(c)(21) of the Act.

weekly wage ("NAWW"). "Claimant's combined awards cannot exceed the amount prescribed for total disability under Section 8(a), plus Section 10(f) adjustments, nor can they exceed the statutory maximum under Section 6(b)." *Price v. Stevedoring Services of America*, 36 BRBS 56, 63 n.12 (2002).

If two-thirds of a claimant's actual average weekly wage is greater than 200 percent of the applicable NAWW, the claimant receives the latter.[53] The claimant is not limited to the maximum rate at the time of injury. *Marko v. Morris Boney Co.*, 23 BRBS 353, 361. Each year, the Secretary of Labor recalculates the NAWW and 200 percent of this amount becomes the new statutory maximum compensation rate on October 1. 33 U.S.C. § 906(b)(3). As long as two-thirds of a claimant's actual average weekly wage remains higher than 200 percent of the new NAWW, a claimant receiving permanent total disability or death benefits is entitled to receive the new maximum pursuant to Section 6(c).[54] *Id.*

As Claimant is permanently totally disabled from his maximum medical improvement date of June 1, 1990 through February 8, 1993, the day before suitable alternate employment was located though the labor market survey referred to above, the maximum compensation he can receive on a weekly basis under Section 6(b) is as follows: (1) June 1, 1990 - September 30, 1990: $660.62 ; (2) October 1, 1990 - September 30, 1991: $682.14; (3) October 1, 1991 - September 30, 1992: $699.96; (4) October 1, 1992 - February 8, 1993: $721.14. Commencing on February 9, 1993, and continuing, Claimant is entitled to a maximum compensation rate of $721.14, since he is permanently partially disabled as of that date.

III. Payment for Scheduled and an Unscheduled Injury

At trial, Claimant argued that he was entitled to payment for both the scheduled injury to his right knee as well as the unscheduled injury to his low back. This issue was not, however, addressed in Claimant's Post-Trial Brief, whereas Employer asserts in its Post-Trial Brief that any scheduled injury to the right knee is subsumed by Claimant's unscheduled injury. In any case, Employer wrote the court on behalf of both parties on August 23, 2002, stating that the parties had agreed that any scheduled permanent partial disability award would be "subsumed" in Claimant's permanent award whether total or partial. Employer asserts entitlement to a credit against any already paid benefits, as well as credit for Claimant's service-related V.A. benefits that

[53]If the claimant's average weekly wage is less than 200 percent of the applicable NAWW, the claimant's actual average weekly wage becomes the basis for the permanent total disability compensation rate, see generally 33 U.S.C. § 908(a), and the claimant is then entitled to Section 10(f) adjustments in the amount of the lesser of the percentage increase in the NAWW as determined under Section 6(b)(3) or five percent. 33 U.S.C. § 910(f).

[54]Per 33 U.S.C. § 906(c): "Determinations under subsection (b)(3) with respect to a period shall apply to employees or survivors currently receiving compensation for permanent total disability or death benefits during such period, as well as those newly awarded compensation during such period."

he has been receiving for the pre-existing right knee injury at the rate of $200 per week.[55] Tr.305-306. Employer further contends that any award must run concurrently, based upon the Benefits Review Board's reasoning in *Padilla v. San Pedro Boat Works*, 34 BRBS 49 (2000), and cases preceding. See, *Brady-Hamilton Stevedore Co. v. Director*, OWCP, 58 F.3d 419 (9th Cir. 1995); *Green v. I.T.O. Corp. of Baltimore*, 32 BRBS 67 (1998), *modified*, 185 F.3d 239 (4th Cir. 199). Finally, Employer contends that any scheduled award should be calculated based upon a finding of a 20 percent impairment, documented by Dr. London on November 5, 1991. See ALJX-4, p.5.

The settled law in this area states that a claimant is entitled to compensation for each separate injury incurred while on the job. However, any combined award cannot equal more than the maximum allowed for an award of total disability, as "[t]o hold otherwise would be to conclude that the whole may be less than the sum of its parts, and we are fairly certain that – although our authority extends to a myriad of matters – we are without jurisdiction to repeal the laws of mathematics." *Green*, 185 F.3d at 243.

Employer as well as the V.A. have been paying Claimant permanent partial benefits since June 1, 1990. However, Employer is not entitled to a credit for V.A. benefits already paid. *Todd Shipyards Corp. v. Director, OWCP*, 848 F.2d 125 (9th Cir. 1988) (LHWCA credit doctrine not applicable to veteran's benefits).[56]

Regarding the issue of the percentage of the scheduled award to which Claimant is entitled, I agree with Employer. After thorough review of the record, I find that Dr. London is the only physician that gave Claimant a rating for the injury to his right knee. Since Claimant has not pointed to any controverting evidence, I find that Claimant suffers from a twenty percent impairment in the right knee, based upon the November 5, 1991 report of Dr. London. The scheduled award shall reflect this.

Permanent total disability: June 1, 1990 - February 8, 1993

An award of permanent total disability subsumes an award of permanent partial disability, where both disabilities were sustained from the same industrial injury. Therefore, Claimant will receive the maximum compensation rate per Section 6(b) of the Act for the period of permanent total disability. His scheduled award for his right lower extremity is subsumed in this award for

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[55]Although this issue was raised at the hearing, it is not addressed in Employer's Closing Brief.

[56]"Given the uniqueness of military service, the establishment by Congress of a separate statutory scheme to cover compensation for disabled veterans, and, most important of all, the plain language of § 903(e) (which extends LHWCA offsets beyond the traditional category of benefits paid under the LHWCA only to benefits paid under *other workers' compensation statutes* and the Jones Act), it is clear that veterans' disability benefits are not included within the scope of the credit doctrine as codified. Accordingly, an injured worker may collect workers' compensation benefits under the LHWCA for the full extent of his injury even though he is also receiving veterans' disability benefits for an earlier injury that contributed to his current condition and forms a part of that condition; no offset or credit is permitted for the veteran' disability benefits." *Todd* at 128.

permanent total disability.

Permanent Partial Disability - February 9, 1993, and Continuing

On February 9, 1993, Claimant became permanently partially disabled. However, the maximum compensation rate permitted under Section 6(b) is lower than what Claimant is theoretically able to collect in compensation under Section 8(c)(21). Therefore, Claimant is still not entitled to any payment for his scheduled disability, as Claimant continues to "max out" under Section 6(b) while he is collecting permanent partial disability.

Claimant may be entitled to his scheduled injury compensation if he returns to his pre-injury employment as a marine clerk. Claimant's heirs may also be entitled to scheduled injury compensation upon Claimant's death.

IV. Unpaid Benefits from June 21, 1993 through April 11, 1994:

Section 7(d)(4) of the Act provides that the Secretary or judge ("ALJ") may, by order, suspend payment of all further compensation to an employee during any period in which he unreasonably refuses to submit to medical or surgical treatment, or to an examination by the employer's chosen physician, unless the circumstances justify the refusal. *Dodd v. Newport news Shipbuilding & Dry Dock Co.*, 22 BRBS 245 (1989). The Board has held that it is a two-pronged test. The refusal must be both "unreasonable" and "not justified" by the circumstances. The burden of proof is on the employer to show that the refusal was unreasonable; if carried, the burden then shifts to the claimant to show that the circumstances justified the refusal. *Hrycyk v. Bath Iron Works Corp.*, 11 BRBS 238 (1979).

In the instant case, Claimant has argued that he ceased treatment with Dr. London because of the doctor's abusive behavior towards him, and thus, Claimant's refusal was both reasonable and justified under the circumstances. See ALJX-3, p.12. Employer cross-examined Claimant on this issue, but did not address it in its Post-Trial Brief. As discussed at length above, I do not find Claimant a credible witness. Based upon this finding, as well as the long-standing reputation of Dr. London within the longshore community and with this Court, I do not believe that Dr. London would push a patient to the floor, refuse to help him up, and instruct his staff not to help as testified to by Claimant. Thus, Employer has met its burden of showing that Claimant's refusal to submit to treatment by Dr. London was unreasonable. Furthermore, Claimant has failed to justify his refusal under the circumstances. However, the statute clearly states that the decision to withhold benefits for such behavior lies squarely in the power of the Secretary or the ALJ. Furthermore, an ALJ may not apply Section 7(d)(4) retroactively, as Employer wishes here. *Dodd* 22 BRBS at 249.[57] Employer did not have the authority to arbitrarily cut off Claimant's

[57]"Section 7(d) requires an employer to obtain an order authorizing it to suspend benefits *before* it takes such action." *Dodd*, 22 BRBS at 249 (italics mine).

benefits based upon its own interpretation of Claimant's refusal as unreasonable and unjustified. Furthermore, Employer has given me no authority for its position, which could be construed as an acquiescence on its part. Therefore, Claimant is entitled to payment for this period.

V. Section 14(e) Penalties and Interest:

Claimant asserts that he is entitled to a penalty pursuant to section 14(e) based on Employer's failure to pay Claimant benefits or controvert Claimant's right to benefits between June 21, 1993 and April 1, 1994. Employer did not address this issue.

Failure to begin compensation payments or file a notice of controversion within twenty-eight days of knowledge of the injury or the date the employer should have been aware of a potential controversy or dispute renders the employer liable for an assessment equal to 10% of the overdue compensation. The first installment of compensation becomes due on the fourteenth day after the employer has been notified pursuant to Section 12(d), 33 U.S.C. § 912(d), or after the employer has knowledge of the injury. 33 U.S.C. § 914(b); *Universal Terminal and Stevedoring Corp. v. Parker*, 587 F.2d 608 (3rd Cir. 1978). Section 14(d) sets forth the procedure for controverting the right to compensation, and it provides that an employer must file a notice of controversion on or before the fourteenth day after it has received notice pursuant to Section 12(d) or after it has knowledge of the injury. 33 U.S.C. § 914(d); see also *Spencer v. Baker Agricultural Co.*, 16 BRBS 205 (1984). The determination of whether an employer has knowledge of the injury is a question of fact and is assessed in the same manner as determining knowledge under Section 12(d). *Scott v. Tug Mate, Inc.*, 22 BRBS 164 (1989).

A careful review of the record shows that Employer did, in fact, controvert Claimant's entitlement to benefits on June 29, 1993, clearly within the 14-day deadline. See RX-2, p.5. Thus, Claimant is not entitled to penalties for this period of non-payment. Claimant is entitled to interest, payable at the statutory rate.

VI. Section 8(f) Relief:

Employer filed an application for Section 8(f) relief with the Director on October 22, 1993. There is no record of a denial by the Director. Nor did the Director make an appearance in this action, in spite of being served notice of all proceedings. On April 25, 2003, an Order to Show Cause why this court should not grant Employer's Application for Section 8(f) Relief was served on the Director. The Director filed a Response on April 28, 2003 (ALJX-5) stating that the Director had reviewed the OWCP file in this case and it did not show a record or receipt of an October 22, 1993 Application for Section 8(f) relief, although an application submitted dated July 1, 1992 was found and was denied by the Director by letter dated August 14, 1992. The Director then stated that "[w]e would have no objection to the issuance of a Finding and Order Awarding Section 8(f) relief if a compensable disability is found." ALJX-5, p.3. As both a compensable

permanent total disability and permanent partial disability has been found, and the Director lodges no objection to an award of Section 8(f) relief under such circumstances, I hereby find that Employer is entitled to Section 8(f) relief. However, for completeness, I analyze such entitlement below.

To obtain relief under Section 8(f) an employer must show: (1) that the claimant had a pre-existing permanent partial disability; (2) that the pre-existing disability was manifest to the employer prior to the injury for which compensation is being awarded; and, (3) that the pre-existing disability contributed to the claimant's ultimate permanent disability in the statutorily prescribed manner. *Director, OWCP v. Campbell Industries, Inc.*, 678 F.2d 836 (9th Cir. 1982), *cert. denied*, 459 U.S. 1104 (1982).

As to the first factor, the mere fact of past injury does not itself establish disability. Rather, "[t]here must exist, as a result of that injury, some serious, lasting physical problem." *Lockheed Shipbuilding v. Director, OWCP*, 951 F.2d 1143, 1145-46, 25 BRBS 85 (CRT) (9th Cir. 1991) (where there is both evidence of complete recovery from a prior back injury and evidence of permanent partial disability, the ALJ must decide the issue of seriousness); *Director, OWCP v. Belcher Erectors*, 770 F.2d 1220, 1222, 17 BRBS 146, 149 (CRT) (D.C. Cir. 1985).

There is ample evidence of Claimant's pre-existing right knee injury.

As to the second factor, actual knowledge of the pre-existing disability is not required. Constructive knowledge will satisfy the requirement. Constructive knowledge may be proved from medical records in existence at the time of the subsequent injury, from which the condition was objectively determinable. *Director, OWCP v. Universal Terminal & Stevedoring (De Nichilo)*, 575 F.2d, 452, 457 (3d Cir. 1978) (heart disease and diabetes mellitus were readily discoverable from claimant's medical record). The medical records need not indicate the severity or precise nature of the pre-existing condition for it to be manifest, so long as there is sufficient information that might motivate a cautious employer to consider terminating the employee because of the risk of compensation liability. *Topping v. Newport News Shipbuilding & Dry Dock Co.*, 16 BRBS 40, 43-44 (1983).

There is ample evidence in the record to establish constructive notice of Claimant's pre-existing injury. Employer submitted the V.A. Hospital medical records from Claimant's treatment and surgery from 1969 through 1971, for his right knee injury. See RX-4 and RX-5. Dr. Miller testified that he had reviewed these medical records as part of his evaluation of Claimant. Thus, Claimant's pre-existing knee injury was manifest to Employer at the time of his subsequent injury on June 27, 1987. This leaves only the final contribution factor to consider.

The contribution factor requires the employer to establish that the ultimate disability is not due solely to the subsequent injury alone. 20 C.F.R. §702.321(a)(1)(iv). If the ultimate disability is partial rather than total, the employer must establish that it is "materially and substantially" greater than the disability that would have resulted from the work-related injury alone. 20 C.F.R.

§702.321(a)(1). To meet this burden, a fact finder must consider what level of disability would have resulted from a claimant's work-related injury if the claimant had not already had a pre-existing disability at the time of the injury. *Director, OWCP v. Newport News Shipbuilding & Dry Dock Co.*, 8 F.3d 175, 185 (4th Cir. 1993) (*Harcum I*); D*irector, OWCP, v. Newport News Shipbuilding and Dry Dock Co.*, 138 F.3d 134*, (Carmines)*. The *Harcum I* Court stated:

> To satisfy this additional prong of the contribution element, the employer must show by medical evidence or otherwise that the ultimate permanent partial disability materially and substantially exceeds the disability as it would have resulted from the work-related injury alone. A showing of this kind requires quantification of the level of impairment that would ensue from the work- related injury alone. In other words, an employer must present evidence of the type and extent of disability that the claimant would suffer if not previously disabled when injured by the same work-related injury. Once the employer establishes the level of disability in the absence of a pre-existing permanent partial disability, an adjudicative body will have a basis on which to determine whether the ultimate permanent partial disability is materially and substantially greater.

8 F.3d at 185-186.

The issue is thus whether Employer has submitted sufficient medical evidence that Claimant's pre-existing condition has made his present disability materially and substantially greater than it would have been standing alone. After reviewing all the evidence submitted by Employer in support of this contention, the undersigned finds that the burden has been met.

VII. Attorney's Fees and Costs:

Under Section 28 of the Act, a claimant may recover reasonable and necessary attorney's fees and costs associated with the "successful prosecution" of his claim. 33 U.S.C. § 928. Claimant is entitled to reasonable attorney's fees and costs for the work done on the issues that Claimant has prevailed upon.

CONCLUSION

Claimant reached maximum medical improvement on June 1, 1990. He was permanently totally disabled from June 1, 1990 through February 8, 1993. Claimant became permanently partially disabled on February 9, 1993, and is capable of sedentary work. He has a residual wage earning capacity of $264.00 per week, giving him a disability rate payable at the maximum amount. Claimant is also entitled to payment for a twenty percent loss to his right lower extremity (knee) at the scheduled rate, which is subsumed in his payments for permanent total disability and for permanent partial disability under Section 8(c)(21). Claimant is entitled to payment for the period of June 21, 1993 through April 11, 1994, with interest thereon, but is not entitled to penalties for the same period. Employer is entitled to Section 8(f) relief. Claimant is entitled to attorney's fees and costs for the issues he has prevailed on.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, and based upon the entire record, the Court issues the following order:

1. Employer shall pay Claimant temporary total disability from June 25, 1987 through May 31, 1990, at the maximum compensation rate, $605.32 per week;

2. Employer shall pay Claimant permanent total disability at the maximum rate starting June 1, 1990, or $605.32, with increases to the maximum rate per Section 6(b) as of October 1, 1990, and each year following, for 104 weeks;

3. Employer shall pay interest on each unpaid installment of compensation from the date the compensation became due at the rates specified in 28 U.S.C. § 1961;

4. Beginning 104 weeks from June 1, 1990, the Special Fund shall pay Claimant permanent total disability compensation at the maximum rate per Section 6(b) through February 8, 1993;

5. The Special Fund shall pay Claimant permanent partial disability at the maximum rate per Section 6(b) from February 9, 1993, and continuing;

6. The Special Fund shall reimburse Claimant for unpaid benefits from June 21, 1993 through April 11, 1994, with interest on the amount owed to Claimant for each unpaid installment during that period, from the date the compensation became due, at the rates specified in 28 U.S.C. § 1961;

7. Employer is entitled to reimbursement from the Special Fund for all permanent total and permanent partial disability payments made 104 weeks after June 1, 1990, the date Claimant's disability became permanent, plus interest on each unpaid

installment of compensation from the date the compensation became due, at the rates specified in 28 U.S.C. § 1961;

8. Employer is entitled to a credit for benefits already paid;

9. All computations are subject to verification by the District Director who in addition shall make all calculations necessary to carry out this Order;

10. Employer shall provide Claimant all the medical care that may in the future be reasonable and necessary for the treatment of the sequelae of his injuries;

11. Counsel for Claimant is hereby ordered to prepare an Initial Petition for Fees and Costs and directed to serve such petition on the undersigned and on the counsel for Employer within 21 days of the date this Decision and Order is served. Counsel for Employer shall provide the undersigned and Claimant's counsel with a Statement of Objections to the Initial Petition for Fees and Costs within 21 days of the date the Petition for Fees is served. Within ten calendar days after service of the Statement of Objections, counsel for Claimant shall initiate a verbal discussion with counsel for Employer in an effort to amicably resolve as many of Employer's objections as possible. If the two counsel thereby resolve all of their disputes, they shall promptly file a written notification of such agreement. If the parties fail to amicably resolve all of their disputes within 21 days after service of Employer's Statement of Objections, Claimant's counsel shall prepare a Final Application for Fees and Costs which shall summarize any compromises reached during discussion with counsel for Employer, list those matters on which the parties failed to reach agreement, and specifically set forth the final amounts requested as fees and costs. Such Final Application must be served on the undersigned and on counsel for Employer no later than 30 days after service of Employer's Statement of Objections. Within 14 days after service of the Final Application, Employer shall file a Statement of Final Objections and serve a copy on counsel for Claimant. No further pleadings will be accepted, unless specifically authorized in advance. For purposes of this paragraph, a document
will be considered to have been served on the date it was mailed. Any failure to object will be deemed a waiver and acquiescence.

IT IS SO ORDERED.

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ANNE BEYTIN TORKINGTON
Administrative Law Judge